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COMMUNICATIONS.

ENTERIC FEVER.*

BY B. H. DETWEILER, M. D.,
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The profession are indebted to Lewis and Gerhard for the pathology of enteric fever, demonstrating that it is not allied typhus, but a disease as specific and well defined as variola or scarlatina—and to Dr. G. B. Wood for its clear nomenclature. It is a zymotic disease, and I shall demonstrate the feasibility of its being stamped out as readily as variola by vaccination. The exciting cause is the enteric germ, produced by decomposition of alvine discharges of enteric patients. The mode of infection is not by contagion, but by absorption of the germ either by food, potable water, or gaseous emanations. I shall not dwell on its entrance into the system by food or potable water, but by inhalation of the enteric germs. They may be derived from sewer gas or exhalations from alvine dejections thrown on the ground or closet. The most notable case of enteric poisoning by sewer gas was that of the Prince of Wales from exhalation from an old obstructed sewer. The cases related by Dr. Murchison at the school at Clapham, England, where 20 boys out of 22 watched the cleaning out of an old obstructed drain, which had been opened two days before the first boy was taken sick, and the contents spread over a garden adjoining the boys' play-ground. Two of the boys died, post-mortem evidence showing enlargement of the glands of Peyer, and the solitary glands; statement made by

Drs. Latham, Chambers, and Watson. The recent epidemic at Princeton, New Jersey, closing up the college a short time, and causing the death of many promising young men, was caused by the drainage of the Institution into a large pit without ventilation. Disinfection answered all purposes, and it is no longer a cause of fever. An epidemic in this county in August, 1881, originated at Stony Gap, and is such a clear manifestation of the absorption of the specific poison of enteric fever, that I will describe it in detail. The Gap is four miles from Cogan Station, on the road to Salladysburg. A camp-meeting was held on a spur of the Alleghenies, in a wood which sloped to the east and south. At the foot of the ridge a branch of Hoagland's run passed; at right angles a road crossed the run to a farm house; below the road the spring was located, just above the run from which the drinking water was obtained. Along this ridge in the woods the tents were pitched. The last tent on the ridge was occupied by Mr. Wurster and family, whose youngest son, a young man who had been ill for a week or ten days, camped with his parents. This was on Thursday. On Thursday night he was taken suddenly ill with free alvine dejections, which were thrown out on the ground back of the tents well up on the hill. In the morning Dr. Cline, of Salladysburg, saw the patient, directed his removal to his home, which was done on Saturday, directing them to bury all discharges. He had a regular attack of enteric fever, which had been endemic on Pine run and Larry's creek, for some years. On Sunday following was the great day, when from three to five thousand people gathered at the camping ground from a radius of twenty

*Read before the Lycoming County (Pa.) Medical Society.

miles. The season was unusually dry, with high temperature, and the springs and streams unusually low; winds from the west. The majority of the people did not stay on the ground over four hours. Some drank of the spring water, others neither ate or drank while there. Dr. Howell, of Cogan Station, states that within ten days after this meeting he had over fifty cases of enteric fever; all of whom stated that they had been at the camp-meeting, many of whom neither ate or drank anything on the grounds. From these centres the fever radiated through the households, until he directed the families to thoroughly disinfect the dejections with carbolic acid. He ordered carbolic acid to be placed in the vessel as soon as emptied, and in this way not only disinfected the stools, but prevented any further extension of the fever. No precaution was taken with the discharges after being disinfected, but placing them in the closet used by the family. In one case where this precaution was not used, the family of Mrs. H. Champion, of Crescent, is particularly unfortunate. One of the family was taken sick after the meeting at Stony Gap, followed by one of the younger children; the one taken first died, the second passed through a long, slow convalescence. For seven weeks the disinfection was carried on with success. As the child improved the mother discontinued the disinfectant, and in ten days the fever attacked two more of the family, one of whom died. A full disinfection was then continued until convalescence was restored, and the family had no further accession to the fever record.

At our hospital we have had at different times enteric fever, but with the use of disinfectants by the attendants, with our over-filled closets, we have never had any extension of the disease to either patients or attendants. The poison of enteric fever must be in the dejections, or the emanations will not cause a true enteric fever with the fever of invasion and the fever of ulceration. Some well-defined cases of the fever of foul emanations have just been discharged from our hospital from the McIntyre coal-fields, where there are a large number of Swedes at work. Most of the residents of McIntyre are supplied with water from a spring, brought a distance in iron pipes. The Swedes live in large blocks or houses in tenement style. The houses are level with the street in front, but about five feet above the ground in the rear, without cellars. Under these houses the cows and pigs find shelter, and all refuse matter and dejections are thrown. The Swedes get their water from wells; one is situated between

these houses. The street is about sixty feet in width. At the rear of one of these blocks, near the well, a trough with drain was built, into which all refuse from the house was thrown. This was obstructed. It was so offensive that Dr. Bullock, the company physician, prohibited the use of water from this well. In the house to which the drain was attached, there were six Swedes ill with a low form of fever. In the house next to the well, on the north, at an interval of sixty feet, there were two Swedes sick. Five were brought down to our hospital, who had morning remission and evening exacerbation, with elevation of temperature; but not the pathognomonic signs of enteric fever, but merely a zymotic fever from filth. Of those treated at McIntyre, one died from hemorrhage of the bladder, another had hemorrhage of the bowels, but not the specific ulceration of glands of Peyer, nor the copious diarrhoea following these fevers. Nor was it continued with fresh infections, after the drain was removed and thoroughly disinfected.

I mention these cases to show that the surroundings were favorable for a severe invasion of enteric fever. There was some diphtheria. The point I wish to impress strongly is, that enteric fever is a disease *sui generis*; it must have the germs of enteric fever to generate itself. These germs are not active in fresh alvine dejections, and if fully carbolicized are innocuous; and the thorough disinfection of enteric stools will stamp out of the zymotic diseases enteric fever, as fully and effectually as vaccination will stamp out small-pox.

DOES DEATH STING?*

BY GEORGE L. BEARDSLEY, A. M., M. D.,
Of Birmingham, Conn.

The dread of dying is quite as intense as the instinct of self-preservation. Indeed, it is not improbable that numbers would care less about living, were the modes of leaving the world a theme for happy contemplation, or an innovation to the routine of plodding, that was agreeable. One is remarkably exempt from the crime of hasty induction, if he affirms that there is no sane or healthy mortal who anticipates his extinction with any degree of pleasure. This generalization is made in the face of the religious exaltation which is declared by the affected as potent enough or so possessing as to overcome the innate fear of dying. It is almost demonstrable that this religious ecstasy is a species of hysteria—if so, the assertion just made holds good. This horror of

* Read before the "Nous Club," of Birmingham, Conn.

passing into the untried country is mainly explained by the tutored notions of the hereafter. A writer has said that the Christian only demurs about dying—the savage counts it a pleasant journey. Even the brute is to be envied for its immunity from encounters with the harrowing apparitions that often follow fast the soul in its escape from the earthly environment.

But with the moral aspects of death we have no concern. If one can rationalize a conception or frame a hope that will assist him to die serenely, quite loath would we be to dispossess him of the inclination. It is the *purely physical* features of dissolution on which just now we are content to ponder.

The material phenomena of death, that is, the process, independent of the "wages of sin," are much more delectable topics for a review than is ordinarily allowed. In its chemical references, dissolution betrays nothing that is repulsive or allied to suffering. Decay is within the domain of the same law as growth. The two are the termini of that series of evolutions which being involves. Now, the molecular changes in repair are never apparent to the sensory centres. The transit from state to state in the genesis of matter is without the cognizance of the feelings equally after birth as during the intra-uterine captivity. No meter has as yet gauged or determined the individual accretions resulting in a healthy assimilation. In the full fruition of the process one sees the gain, but never can he count the steps, much less is he sensible of the mutations. The germination of a cell is, strangely, so quietly perfected that no tissue can predicate of itself what are its interstitial changes. The function of growing is automatic—the individual renders no assistance, and without the least cerebration or effort of consciousness, is operated upon by forces whose silent combinations can never be registered or criticised. The same physio-chemical energies are concerned in the cataclysm of the cell as in its proliferation; only the reciprocity is uneven, the balance between repair and waste is lost, or rather is in favor of the latter. The function of dying is absolutely vegetative—we fall to pieces like a flower. This very fact, that the process is chemical, confirms us in the conclusion that the final "three" is as painless, as the inconvenience is nothing to the foetal pilgrim when he touches on daylight. A moment's examination of the way we are to die will show marks of goodness in our "taking off." The degree of sensibility is proportioned to the integrity of the tissues. An inflammation heightens it; age depreciates it.

Any defect in nutrition disturbs the comfort of the individual until the carbonic acid generated in the devitalization of the blood becomes fixed in the cells or is no longer displaced. The sensory ganglia everywhere part with their irritability by virtue of this poison, and cease to conduct currents. The criteria of death are being satisfied, and the process is consummated when this extinction of sensibility prevails at the ultimate filaments. During the progress of this dissolution of the nerve-force, this creeping on of the numbness of death, the individual is rapidly passing into a condition of repose, and instead of torture or pangs, a degree of self-satisfaction oft approaching to enthusiasm is realized. The sensations peculiar to the therapeutical operation of opium, hashish, ether, etc., are not improbably akin to the mental activities of the dying. Barring the hallucinations experienced in the stupor as it gains on the subject, the moribund is familiar with naught that borders on suffering. This carbonic acid has poisoned or narcotized the several ganglia, and reflex productions are interdicted. A consummate analgesia prevails. In short, the notion of pain is forbidden the instant that any stimulus fails to excite a response. The condition to this irritability is that the nerve centre and track be sound. If this vigor vanishes, reflex phenomena are at an end, and suffering, physiologically speaking, is impossible, because of the arrest of the function of the sympathetic.

Fortunately, for a wholesome study of one's demise, there are assurances abundant, from vivisection, the testimony of those who have been restored to consciousness, and the affirmations of the dying, that there is no physical recoil from death. Burney tried hard to resist the efforts made to resuscitate him from drowning, so bewitched was he by his prolonged slumber. Dr. Solander, the traveler, was so delighted with the sensations of excessive cold, that he was the first to lie down in the snow to realize the luxury of such a death. Wm. Hunter was sorry he was not able to "write how easy and delightful it is to die." Infants die as serenely as they breathe, and not a few among the advanced in years treat death as a friend to their infirmities. Hanging is, naturally, rated next to crucifixion, a most distressing procedure. But it is reported of those who have been saved from the strangulation, that the agony promised to be brief, and was rapidly replaced by hallucinations of a fascinating variety.

One would feign believe that the kind God who suffered us to feel no sigh in coming, would take

no delight in turning our farewell into writhing. Nay; he does not quit us at the last. He is our greatest benefactor in allowing us to sleep out of weariness. Death is, assuredly, no tax-collector—its "jaws" are not the clutches of an assailant—there is no "victory to the grave"—the ghost speeds away from us as it entered, with no ruffle. The sense of death, as Shakspeare has it, is most in apprehension. It is the fear of the lonely night, not the throes of nature, that makes the leaving painful. Those who are self-possessed, or who are not racked by unwelcome surroundings, or who are not terrified by a cultivated awe about the damnation bottled up for special misdemeanors, these sink into the embraces of death with a longing for the lull it brings to the heavy heart and jaded muscle. The countenance of those who have died in an instant, as from lightning, aneurism, or pistol-shot, is remarkably placid; and not infrequently is it chronicled of this or that death-bed, that in spite of the violence of the inflammation, the patient met death with ease, because of a "saving faith." It will hardly be allowed that a faith can be "saving" enough to be antidotal to a vigorous pain; but the statement is nice, by way of confirmation of the theory that the real agony of the dying is not the reflex disquiet, but the setting in order for leaving.

"To die is landing on some silent shore
Where billows never break, nor tempests roar,
Ere well we feel the friendly stroke."

HIPPOCRATES AND HIS PRACTICE.*

BY THOS. S. SOZINSKEY, M. D.
Of Philadelphia.

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Whatever may have been the success of the various *Æsclepias*, that of Cos was destined to make the greatest impress on the medicine of the future. It was the good fortune of this institution to have in connection with it, at the acme of its career, a great author as well as physician. Hippocrates, a native of the island, rendered the fame of the Coan school imperishable, and gave to his fellow-men throughout the world, in all time to come, a legacy of incalculable value. Through this early and great medical writer, his alma mater has been made, in a manner, that of the medical men of all ages. From Cos sprang forth, at the touch of an humble man, a mass of medical knowledge, wonderfully pure and good, which

*Extracts from a chapter on "*Æsclepias* and the *Æsclepiades*" of an unpublished work. References are omitted.

constitutes the main body of the real medical science of our own day.

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It is more than probable that except for a short period at first, the system of treatment pursued by the *Æsclepiades* varied within wide limits; and it is equally certain that the superstitious element lessened as time passed. Between the principles of practice of *Æsculapius* and those of Hippocrates there is a very great difference. Those of the former will be given later; but of those of the latter I may say here that they were essentially scientific.

To Hippocrates every disease had a natural cause, and was to be cured by natural means. He was one wont "to consult nature herself about nature," as Bacon has somewhere wisely advised. He did not attribute any morbid condition to any spiritual power, good or bad, and hence in his practice did not resort to conjuration or any related means of cure. Even of epilepsy, the so-called sacred disease, he said: "It is thus with regard to the disease called sacred: it appears to me to be no wise more divine nor more sacred than other diseases, but has a natural cause, from which it originates, like other affections." And again: "Men regard its nature and cause as divine from ignorance and wonder." As regards holding disease to be divinely inflicted, he very properly remarks, "I do not count it a worthy opinion to hold that the body of man is polluted by God."

Not only in the principles of medicine, but in its practice, Hippocrates was wonderfully sound, even when judged from the standpoint of the art in our day. In truth, for extent and profundity of medical knowledge and philosophy, between him and what modern would we think of instituting a comparison? Sydenham has been likened to him, but although I am an admirer of the English physician, I do not hesitate to say that he was neither in breadth nor depth any such man as the Coan. As a writer on the prevention and cure of disease, Hippocrates remains *facile princeps*.

Let it not be supposed that my admiration for Hippocrates is unreasonably great. His works are truly a surprise to even the well-read modern. Very many of the so-called discoveries of recent times may be learned by turning to them. I speak advisedly. I will cite instances.

Thus, of the treatment of open sores, he says: "In these cases no part is to be exposed to the air." Dressings of "wine and oil" and "pitched cerate," are directed to be used.

Again, in treating fractures, in connection with certain splints, he advises that "a soft, consist-

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ent, and clean cerate should be rubbed into the folds of the bandage." And he says: "If you see that the bones are properly adjusted by the first dressing, and that there is no troublesome pruritus in the part, nor any reason to suspect ulceration, you may allow the arm to remain bandaged in the splints until after the lapse of more than twenty days."

Still again, in regard to the reduction of a dislocation at the hip-joint, he says: "In some, the thigh is reduced with no preparation, with slight extension, directed by the hands and with slight movement; and in some reduction is effected by bending the limb at the joint and making rotation."

Here we have the practical side of the germ theory of disease, the permanent dressing of fractures and the reduction of dislocations by manipulation.

I might go on and recount numerous other matters alleged to be new and of which we hear much, but it is unnecessary. I may add, however, a few items of interest.

"Bleed," says he, "in the acute affections, if the disease appears strong, and if the patients be in the vigor of life, and if they have strength." Has any modern spoken more wisely on the subject?

Here is a statement worthy of the attention of unbalanced theorists of our day: In fevers and pneumonia, heat "is not the sole cause of mischief."

He gives directions for the use of affusions with "waters of various temperatures," in "cases of pneumonia," of "ardent fevers," and of other diseases. This treatment he thinks "suits better with cases of pneumonia than in ardent fevers."

In that inimitable book, his "Aphorisms," it is said: "In general, diseases are cured by their contraries." There is no exclusive allopathy or homeopathy or dogma of any kind in that statement; it is the sentiment of a scientific physician.

Medicine was evidently far advanced in the days of Hippocrates, and he was certainly a learned and sensible practitioner of it, even "the prince of physicians," as Galen, I think, has somewhere characterized him, as well as one who did much to make it what he himself pronounced it to be, namely, "of all arts the most noble."

—The University of Heidelberg has been offered the sum of 100,000 marks, on condition that it would admit women to its courses. The offer was refused.

HOSPITAL REPORTS.

NEW YORK HOSPITAL.

CLINIC OF PROF. WILLIAM H. DRAPER.

Reported by W. H. SEELYE, A. M., M. D.

Apoplexy.

The patient was admitted January 7th. He is thirty-one years of age, and married. He was brought in in an ambulance from Chambers street, where he was picked up in an unconscious condition, having fallen down suddenly while walking. He was suffering then with signs from which the diagnosis of cerebral hemorrhage was made. There is no personal or hereditary rheumatic, syphilitic, or pulmonary history. Has not used alcoholic liquors to excess. Has worked in a wine cellar, and while so employed he had an attack of chills and fever. For the past three years he has been gradually losing strength, and has complained much of pain in the occipital region, which was not relieved by treatment, and of some nausea and vomiting. He has recently passed large quantities of water, and has had to get up several times during the night to empty his bladder, and the urine contains albumen in large quantities, and hyaline and granular casts.

On the evening of his admission his temperature was 99.6°. In appearance he was well nourished. He could not speak, and he opened his eyes slowly. The pupils were narrow, but the right was a little larger than the left. He lay in an unconscious condition, but he recovered sufficiently to try to move his limbs, and it was found that both the lower and the upper extremities on the right side were paralyzed, and he tried to lift the right arm and hand with the left, and succeeded. There was no paralysis of either the upper or lower limb upon the left side. In the right arm and hand, sensation was retarded and blunted, and reflex was abolished, and there was anesthesia over all the right side.

January 8. The patient's condition has improved somewhat. There is some reflex obtained in the left toe. There is no diminution of reflex in the facial muscles. The pulse is full and slow. There have been no involuntary evacuations from the rectum or the bladder. The bladder was not found to be distended, but the urine was drawn off with a catheter, and it measured about three ounces. It was largely albuminous, and contained muco-pus, and granular and hyaline casts. Patient is very dull, and does not mutter, or protrude his tongue when told to. There is facial paralysis upon the right side, but not on the left.

Gentlemen, this patient presents some interesting features in connection with the subject of hemiplegia. He is a young man to suffer from this malady, and yet his disease is one which is not confined to any age. You will see cases of it occurring in childhood, in adolescence, and in adults of all ages, as well as in those who have passed the prime of life. The first point to which I wish to call your attention here, is the association of renal disease with hemiplegia. I have spoken of this association before, and I told you that hemiplegia was commonly associated, not only with renal disease, but with one other very common condition, and that is enlargement of the

heart, with dilatation of the left ventricle, and not only with this, but with that other condition which is the essential element in both the previous ones, namely a diseased condition of the arterial system, or an arterial degeneration, or a fibrosis, as it has been called. This affects, not only the arteries, but the capillaries also; and it is in connection with this arterial fibrosis that you very frequently find that form of renal disease which is attended with a granular atrophied kidney. And with this interstitial nephritis you frequently find an enlargement of the heart, and especially enlargement with dilatation of the cavity of the left ventricle. Now this man not only presents all of these features, but the catastrophe itself, in his case, has been preceded by what may be regarded as the classical prodromata of apoplexy in this condition. One of the commonest of the prodromata is persistent headache, and you have heard it said that this man has had severe occipital headaches frequently repeated, and that they were not amenable to treatment. He had in fact uræmic headaches, and these uræmic headaches are one of the commonest symptoms of this form of interstitial nephritis.

In making the physical examination, the first point to which I wish to call your attention is the heart. The apex-beat I find in the sixth intercostal space, and a little to the inside of the nipple line. The cardiac impulse is forcible and heavy, and is distinguishable not only over the region of the apex, but also in the epigastrium. The area of præcordial dullness begins a little lower down than usual. The upper line of dullness begins at the superior margin of the fifth rib, and it extends downwards to the seventh rib, and laterally to half an inch outside the nipple. This increase in the area of præcordial dullness is due mainly to an enlargement of the left ventricle. And when this takes place, you are very apt to have this change in the region of præcordial dullness. There is also here some enlargement of the veins just under the skin of the chest, which is suggestive of some obstruction to the free return of blood in the venous circulation.

The next thing to which I ask your attention is the condition of the arteries. The temporal artery you see is very tortuous; and this is a sign of senile change in the tissues. And I find upon feeling the radial artery that the pulse is full, and there is an unusual degree of tension, and it is not easily compressible; and the pulsations are unusually visible not only in the wrist, but above the elbow in the brachial artery, and to some extent in the neck. Now it is in this condition of arterial degeneration, with hypertrophy of the heart and degeneration of the kidneys, that you are very apt to get the accident which has befallen this man.

But you may ask if I am quite sure that this is a case of cerebral hemorrhage, and if there may not rather be a plugging of an artery by an embolus or a thrombus. And this is a reasonable question, because he is a young man and he has heart disease besides, which is suggestive of a cerebral embolism. But I examined his heart yesterday, and I did not find any disease of the aortic valves, nor any murmur or other evidence of vegetations in the heart, and so I was inclined

to exclude the idea of embolism as the cause of this trouble. But again you might say that perhaps an arterial thrombus has closed up a vessel of considerable size, and from the resulting anæmia and softening of the brain tissue about it, you have an explanation of the condition in which we find him. It is true that there is a certain degree of probability in both of these suppositions, but no more so than of its being the result of a hemorrhage. It is not always an easy matter to diagnose the cause of a hemiplegia. I have no doubt but that there is an organic lesion here; but whether it is a cerebral hemorrhage or thrombosis or embolism, it is not possible to say with any positiveness. But the fact that you have here, as in the great majority of the cases of cerebral hemorrhage, this association of an hypertrophied heart and degenerated arteries and granular kidneys, which I have told you about, is the principal reason why I believe that a hemorrhage into the brain is the cause of the hemiplegia in this case. But if there were a history of a fit of great anger or sudden excitement, preceding the accident, and if there were cardiac murmurs and hypertrophy of the heart due to valvular disease, or if the accident had occurred during an attack of rheumatic endocarditis, I should then think that there was probably a cerebral embolism.

Now, this case is interesting in another point. It is a case of the apoplectic onset of hemorrhage. This man fell suddenly in the street as in apoplexy, and he was picked up in a partially unconscious condition, with resolution of all the limbs, and with no wound of the tongue to show that there had been any convulsion. But after he came into the hospital he recovered sufficiently to move the limbs on the sound side, and to make the common gesture which is almost diagnostic of hemiplegia, namely to lift the arm on the paralyzed side with the hand of the sound side. But there was no other evidence of consciousness, and he could not speak. There was anæsthesia all over the right side of the body, and reflex was abolished. Loss of sensibility in connection with loss of motion is not always observed, and in many cases there is loss of sensation which is not accompanied by loss of motion. But here there was both. This is the important point, as it gives us the opportunity of locating with more or less precision the place at which the hemorrhage has occurred. I say with more or less precision, because the localization of brain lesions has not yet been reduced to great accuracy. But the knowledge on this point is approaching precision, and it will probably some day be pretty exact. We sometimes know where the lesion is, for in some particular localities we get special symptoms. It was formerly thought that a lesion in the corpus striatum would produce only a loss of motion, and it was claimed by many that if the lesion was in the optic thalamus you would get, in addition to a loss of motion, a loss of sensation. Others extend this area in which there is loss both of motion and sensation to the pons variolii, where all the fibers which come from the cerebrum are found together. In some cases of hemiplegia the loss of sensation is temporary, while the loss of motion remains. In these cases it is probable that the lesion is small, and so only affects temporarily the centres which control sensation. It

seems in this case probable, from the fact that there is loss of sensation as well as motion upon the right side of the body, that this lesion is in the neighborhood of the pons. And inasmuch as the coma is not profound, but he is in a state of semi-consciousness, I think that there is reason to suppose that the hemorrhage is not a very large one, but is merely of sufficient size to produce a loss of power and sensation, with a partial but temporary loss of consciousness. The loss of consciousness is often very profound, and if it remains so for twenty-four or forty-eight hours, the patient will probably not recover his senses. But if the loss of consciousness is not complete, though it may continue so for many days, there may yet be entire recovery of it.

There is one other symptom noticed here which you sometimes see developed very early, and that is a certain amount of rigidity of the limbs upon the right side. This is present now to a slight degree in the lower limb of this man; but it is usually more marked in the right arm, though it is not so here. But if I attempt to turn his head towards the left side it occasions him pain in the left side of the neck, and there is rigidity of the muscles of the neck upon that side. In some cases this rigidity of the muscles is absent and sometimes it is present, but I do not know why there is this variation. But we may speculate as to the cause of it. It may be due to the irritation provoked by the clot; but this I do not know. It is present in a certain proportion of cases, and where it does not exist there is generally a good deal of pain provoked if any attempt is made to flex or extend the rigid muscles. It affects the flexors, as a rule, more than the extensors. Late rigidity of paralyzed muscles is a very common phenomenon.

In regard to the prognosis of such a case, where the consciousness is not entirely abolished and is incomplete, the prognosis is good that the patient will ultimately recover consciousness, although he may remain in this state for two or three weeks. As to the prognosis concerning the hemiplegia, there is not so much to be said in favor of his recovery. When he returns to consciousness it will probably be found that in addition to the paralysis there will be more or less aphasia. But it is not absolutely necessary that this should be the case, for you sometimes see right hemiplegia with no accompanying aphasia. If the lesion is located far back in the hemisphere, there will not be any aphasia. This morning he spoke a little, and said that he felt very well. So he may recover his speech perfectly; but it is not safe to say so. As to the prospect of recovery from the hemiplegia, I can hardly judge. But he is a young man, and if the clot is not extensive, he may recover the use of the right side to a very considerable degree. For the clot may be so small that it will be gradually absorbed, and the connections between the divided nerve fibres may become re-established, and so he may regain at last the free use of the muscles upon the paralyzed side of the body. However, with this condition of a hypertrophied heart, and atrophied kidneys, and degenerated arteries, this is a rather exaggerated expectation. But you should be very guarded about your prognosis in such a case.

Now as to the treatment. Perhaps, there is

nothing more embarrassing to a young doctor than to be called suddenly to a case of apoplexy. The old traditions as to the treatment of this disease still have a pretty strong hold upon the popular mind. Something energetic must be done; and blood-letting and hot applications to the feet, and powerful doses of purgatives and the like, is what is expected by the friends and those who are interested in the patient. And the man who should calmly consider the situation, and only do the little that needs to be done, would be suspected of incompetence. But there is no occasion for any energetic procedure immediately after an attack. Consider the conditions present in this man for instance—the diseased arteries, the hypertrophied heart, and the atrophied kidneys, associated with a hemorrhage into the brain, and a state of partial unconsciousness, with hemiplegia. Now what is there that you can do for his relief? Almost nothing. You may say, why not bleed him? Well, you might, if you were sure of your diagnosis. If you were brought to a man in whom you were in doubt as to the existence of a hemorrhage, but if you found that there was great fulness of the vessels of the head, and that there was albuminuria and evidences of a granular atrophy of the kidneys, and a hypertrophied heart, and a full pulse with irregular arteries, and if you found him lying in a state of complete coma, you would not do far wrong if you should bleed him. These are the cases in which bleeding has gained its great renown, because they so closely resemble the coma of uræmia, where blood-letting is often followed by relief. So though an attack of coma is not necessarily connected with blood extravasation, you will not do any harm by bleeding. But if it is due to a cerebral hemorrhage, you will not do any good, for this will not relieve him from the consequences of the hemorrhage.

Here it would not be necessary to bleed the patient, for he lies quiet, in a partial stupor, and has an easy pulse with moderate tension, and there are no signs of cerebral congestion. And with these signs of cerebral hemorrhage, how are you going to help him any by bleeding? I should even question the utility of purging, though I don't know as it would do any harm. But that is not a very philosophical reason for administering drugs. You can not do much for his relief, and so he may be safely left alone, only giving your attention to proper feeding and to regulating the proper operation of the kidneys and rectum, and all the organic functions.

Empyema.

The next patient is a man 37 years of age, a silversmith, and married. Was admitted to the hospital January 6. His father died of heart disease. The family history is otherwise negative. Patient does not use alcoholic liquors, and has never had any venereal disease. His general health has been feeble for a number of years. Ten years ago he had fever and ague. And then he had frequent bilious attacks, but has not had any of late. He was also very subject to attacks of cardiac palpitation. Seven or eight years ago he had his first attack of asthma, which finally disappeared; and he was not troubled again until twelve months ago, when the asthma re-

turned. There was a panic at that time, and he was thrown out of employment, and he thinks anxiety and worry brought on this attack. He got better, however, but ever since, upon exertion or after becoming fatigued, he has been troubled with shortness of breath. Three weeks ago he took a severe cold, which caused him to cough violently and to raise a viscid, muco-purulent expectoration. Shortness of breath became extreme, and he had a feeling of weight and oppression about the chest. There was no pain or vomiting. He is a moderate eater, and his bowels are regular. His expectoration contains no blood. The shortness of breath and oppression have continued up to the time of his admission, and his feet and legs have become swollen. On admission his pulse was 92, respiration 30, and temperature 102.2°. He passes two pints of urine a day, and it is dark-colored, has an alkaline reaction, and a specific gravity of 1.017, and contains granular hyaline and fatty casts.

Asthma, gentlemen, is a very vague term, as used by patients, and even also as used by many doctors. Strictly speaking, asthma is a nervous dyspnoea, and the term should be confined to that sort of dyspnoea which is dependent upon a spasm of the bronchial muscles. Dyspnoea is often spoken of as asthma where there is no real bronchial spasm. Asthma in the sense of dyspnoea, for these terms are popularly convertible, is something from which many people suffer. Now this patient speaks of having had an asthma lasting a year; and what is important to note is, that he says it began during a panic, when he was out of employment, and he was consequently suffering from more or less anxiety, trouble, and distress. He got better, but note, he did not get entirely well. After unusual exertion or fatigue, and from emotion and other causes, he had more or less difficulty of breathing. What I am coming at is, to say that the dyspnoea here is probably connected with a defective blood circulation; and I suspect that this is dependent upon a centric difficulty, and that when we come to examine him, we shall find some change in the cardiac condition from the normal.

Now the attack for which he came into the hospital dates back three weeks, and the subjective history since is one which points to a weak chest; and now we are to find out by the physical examination wherein this weakness exists.

I find the apex beat in the fifth intercostal space and one inch outside of the nipple line, and I get a mitral regurgitant murmur and a friction murmur besides, and I find evidence of a cardiac hypertrophy. The jugulars are also enlarged and full. To save time, I will tell you briefly what is the condition here, as it has already been made out by a previous examination. The patient has pulmonary lesions of considerable extent. He has a dry pleurisy in the left lung, and there is evidence of empyema upon the right side of the chest. To show this, the doctor will now puncture the chest in the eighth intercostal space in the line of the axilla. It is a good plan before puncturing the chest to draw the skin down tightly over the point at which you intend to insert the needle, so that when the needle is withdrawn the line of puncture in the skin and the muscles will not be the same, and therefore the

skin will close over the opening in the muscles, and so act as a valve to prevent a further outflow of fluid, or the entrance of air. You see now the yellowish purulent fluid which the doctor has drawn out with the hypodermic syringe, and it is evident, therefore, from this test, that we have here to deal with an empyema, probably of recent origin. And this it was, no doubt, which gave rise to the symptoms from which he has suffered for the last three weeks. But in addition to this, there has long existed a pleurisy upon the left side, and a consequent embarrassment of the lung from pressure, and a bronchitis and a hypertrophied heart, and albuminuria. And therefore he is laboring under conditions which are decidedly adverse. Now the question arises as to the advisability of treating him for the empyema. It is not a very favorable case for trying it. But we shall keep him here for some time, and as his condition has already improved considerably, I think we will select what is known as the "thorough drainage" plan of treatment. This consists in making two openings through the chest-wall into the pleural cavity, and after evacuating the fluid putting in a rubber drainage-tube, which is perforated at its central portion, through which the discharges may drain and the cavity may be washed out. And with antiseptic precautions and proper dressings, I think we may get reasonably good results. But we cannot expect that they will be as good as they would be in an otherwise healthy man.

MEDICAL SOCIETIES.

CHICAGO MEDICAL SOCIETY.

Stated meeting, July 14, 1884. Dr. D. A. K. Steele, President.

The following scientific papers were read:

"A Report of a Successful Case of Abdominal Section for Pyosalpinx, Treated by Volkmann's Method," by Dr. F. H. Martin.

"Fracture of the Clavicle, and its Rational Treatment," by Dr. S. W. Wetmore.

"Rhinolithiasis, and Report of a Case of Forty Years' Development," by Dr. Jefferson Bettman.

A Successful Case of Abdominal Section for Pyosalpinx, Treated by Volkmann's Method.

By Dr. F. H. Martin.

Mrs. T., American, married, ætät 27; weight, 200 pounds; no children, yet desirous of becoming a mother; four years ago aborted a three months' foetus. Consulted the writer one year ago, because of suspected pregnancy. She had many of the symptoms of pregnancy, such as morning sickness, enlargement and pain about the mammary glands, enlargement of the abdomen, etc., although she flowed regularly every month for the four months, that she considered herself pregnant, yet this was scanty. An ordinary digital examination was made, but no diagnosis was made. Advised the patient to call again, which she did in two months. Examination a second time resulted unsatisfactorily in ascertaining the true state of her condition. In consultation with Dr. W. H. Byford, who also made a careful physical examination, he was inclined to pronounce her case one of pregnancy, as the pa-

tient expressed herself that she felt very decided foetal movements, together with the other characteristic symptoms that were present, although her menstrual flow appeared scantily each month. Five months subsequently was again consulted. In company with Dr. R. W. Bishop, and whilst the patient was anesthetized, a very thorough examination by bimanual manipulation per vagina and rectum was made. The small, undeveloped uterus was found crowded close behind the symphysis pubis and inseparable from a large firm-walled tumor, about the size of a five months' gravid uterus, occupying Douglas' cul de sac, and extending upward nearly to the umbilicus, and occupying a position a little to the left of the median line. Owing to the corpulency of the patient and thickness of her abdominal walls, it seemed impossible to make an accurate diagnosis. The uterus measured $2\frac{1}{2}$ inches in length.

The patient was again taken to Dr. Byford, and after a careful examination at this visit, he pronounced the malady a fibroid tumor of the uterus. However, with commendable conservatism, he advised that an operation be delayed, although the patient was suffering greatly from pressure of the tumor on the bladder and rectum, from intense backache and other reflex manifestations. In two months time her suffering had greatly increased, and she implored its removal, or that something radical be done to relieve her.

Operation, May 15. Assisted by Drs. R. W. Bishop, L. L. McArthur, E. L. Hollister, L. T. Potter, S. Black, T. H. Swayne and E. J. Doering. All necessary antiseptic precautions were observed. Abdominal section was made. Incision eight inches in length, extending from quite near the umbilicus to symphysis pubes, omentum firmly adherent to the tumor, adhesions covering a space of three or four inches in diameter, these were ligated and carefully separated. Not until the omentum was separated, was the true nature of the tumor revealed, which proved to be a large dilatation of the left Fallopian tube, with thick, firm walls. Tumor so generally adherent to the surrounding tissue that it resembled a fibroid or other solid tumor. Fluctuation was very indistinct, and only by introducing the needle of an aspirator, were all doubts of it removed. Upon deeper examination, the tumor was found to develop from the left horn of the uterus, on the opposite side of its attachment were the remains of the fimbriae of the tube and ovary of the left side, the walls of which were muscular in character and very smooth. The operator intended removing the tumor in its entirety, clamping the small pedicle, and attaching it to the inferior angle of the wound; but this was found to be impracticable, for the tumor was so universally adherent to the surrounding tissues, and the intestines were firmly adherent upon almost its entire surface above, the rectum being involved so as to appear almost as if it were part of the tumor; and Volkmann's method of treating abscesses and similar tumors was resorted to, viz., stitching the walls of the tumor or abscess to the peritoneal edges of the abdominal wound, and treating it after union has taken place, as an external abscess. The opening in the abdomen was closed, with the exception of the lower angle, where about three inches was left patulous, the tumor was stitched to the peri-

toneal edges of the open wound, so that about two inches in diameter of its upper surface remained exposed. The wound, of course, was dressed antiseptically. Examination on the fourth day after the operation revealed the tumor firmly adherent to the abdominal wound. A free incision was now made into the tumor, and a double half-inch drainage-tube inserted sufficient to reach the bottom of the abscess. More than a quart of healthy pus was evacuated; the cavity was then thoroughly cleansed with a two per cent. solution of carbolic acid, and again immediately after with a saturated solution of thymol, to prevent any tendency to carbolic-acid poisoning. Then at night and morning the cavity was cleansed with a solution of corrosive sublimate, 1 part to 3000, and the external wound dressed with corrosive sublimate gauze, 1 to 2000. During the succeeding ten days, the patient's condition was favorable, when the temperature suddenly rose to 102° F. Eleventh day it reached $103\frac{3}{4}^{\circ}$ F. Respiration irregular and frequent; pulse 160. Dr. C. Fenger saw the case at this stage; he decided that the lining of the abscess was absorbing purulent matter, which produced the general constitutional disturbance. The opening of the abscess was enlarged by blunt pressure, and the inner surface scraped with a dull curette, and cauterized with a 20 per cent. solution of chloride of zinc. Further search revealed an abscess in the thick abdominal walls, which was opened and drained. After this procedure, the temperature became normal. She continued to improve until the abscess entirely discharged itself, the wound closed, and perfect recovery ensued.

DISCUSSION.

Dr. J. H. Etheridge inquired of the author what his diagnosis was, before, as he stated, "it was confirmed while operating?" He thought the case had been managed in a most consummately skilful manner, and was much pleased to hear the report. This speaker believes that great advancement has been made in treating these cases the past few years, to ward off suffering and save life; and that the disease is extremely common, only we cannot diagnose it. A physician of Denver introduces the whole hand into the vagina of a patient whilst she is under the influence of an anæsthetic, and by conjoined manipulation is rendered more able to arrive at a conclusion in the differentiation of this from other disease of the pelvic cavity. He would also inquire, What was the result of a rectal examination? This gentleman then presented the history of a case of pyosalpinx, and exhibited the pathological specimen removed from a case that had recently been under his care. There is nothing particular that needs to be mentioned about the operation.

The case is the ulterior result of perimetritis, which extended and brought about the salpingitis. This author stated he had no doubt but what an old gonorrhœa, where it is latent and the discharge scarcely if at all perceptible, was one of the causes of producing it. A long-continued chronic orchitis also may produce it, yet upon inquiry of Dr. A. H. Burr if such difficulty was traced to the husband of the patient of the case he now presented, he was answered negatively.

He now verbally gave the *Pathology* of this case, which, condensed, is as follows:

The right ovary was free from adhesions, and was in a comparatively healthy condition.

The right Fallopian tube was inflamed and enlarged. Its fimbriated extremity was so changed and enlarged by previous inflammation that its fimbriae were obliterated and the canal stenosed absolutely. It, the fimbriated extremity, was free, being attached to nothing.

The left ovary was imbedded in an accumulation of inflammatory exudate, which involved the broad ligament and tube in an indistinguishable and non-separable mass.

The left Fallopian tube was inflamed and enlarged throughout its whole length. Its fimbriae were enmassed and indistinguishable. Its canal was patulous, the distal mouth opening into the abdominal cavity. The outer third of the tube was inseparably agglutinated to the upper surface of the ovary. It was impossible for the free end of the tube to be brought in contact with the ovary, because of the obliteration of its fimbriae, of its universal enlargement, and of the complete encapsulation of the ovary.

A serous cyst, the size of a pullet's egg, was developed in the inflammatory adhesions of the broad ligament and tube. It was a simply serous accumulation from the perimetritic inflammation.

A minute par-ovarian cyst had commenced developing beneath and outside of the broad ligament cyst.

The condition of the tubes showed that the patient was irretrievably and hopelessly sterile.

The inflammation and patulous canal (opening into the free abdominal cavity) of the left Fallopian tube constituted the chief source of danger to life. Pus and inflammatory product extruded from the fimbriated extremity, and was constantly liable to start up renewed attacks of inflammation, which would soon have fatally exhausted her. From this source she has had doubtless many minor attacks of perimetritis already, each in turn increasing the exudate which encapsulated the left ovary.

The irritation from incarceration of the left ovary in menstruations is probably what led to the menorrhagias which were progressively anæmiating her.

The pachy-hemorrhagiparous condition of the pelvic peritoneum, which produced an hæmatocele nineteen months ago, together with the salpingitis, perimetritis, and menorrhagia resulting in progressive anæmia, emaciation, and debility, seemed to demand imperatively the entire removal of the uterine appendages.

She lived but a few days after the operation, and succumbed from the asthenia and hopeless condition existing prior to being operated upon.

Dr. H. P. Newman's experience in these cases was that they are difficult to diagnose and are very troublesome ailments. He thought the successful case as reported was extremely well managed indeed, but I would like to ask the writer to explain more minutely his means of diagnosis during the earlier stages of the disease. The speaker would not attempt to make any extended remarks, for the paper and the gentleman preceding him had stated about all there is to be said upon the subject.

Dr. L. L. McArthur, regarding Volkmann's method. He had seen it carried out in the treatment of three cases of abscess of the liver, and one case of abscess of the spleen, with slight modifications. This was done in the service of the city hospital, and is there approved.

Dr. L. T. Potter inquired if the neck of the uterus was the normal length; and would he have been justified in passing a probe earlier, if the tumor pressed the uterus to such a degree that the uterus resembled this organ containing a fetus?

Dr. Martin replied as follows: that he did not discover the exact nature of the tumor until the time of the operation, and not until after he had entered the abdominal cavity and introduced an aspirating needle. Fluctuation was very indistinct. The tumor seemed very dense. The abdominal walls were at least three inches thick, so that great difficulty was had in trying to outline any form of tumor, even by the minutest examination. The cause of it could not be ascertained. He was in doubt for months that pregnancy existed. Thought perhaps one cause of these tumors might be from stoppage of the uterine orifice of the Fallopian tubes. It was utterly impossible to diagnose the case at any stage. Bimanual manipulation through the rectum and otherwise availed nothing. The rectum was adherent in every direction to the (as supposed) uterus or tumor. Other physicians who saw the case from time to time were in doubt, as was stated in the paper, in their diagnosis, and several different opinions were offered by them. He was afraid to manipulate the womb to great extent or to introduce a probe, as she was very desirous of giving birth to a child, and nearly all the evidence showed the uterus to contain a fetus; and yet he examined her two or three times before the uterus was found. It was crowded close to the symphysis pubis. The neck of the organ was not in the position it usually occupies when a woman is pregnant. The uterus was the normal size.

Fracture of the Clavicle and its Rational Treatment.

By Dr. S. W. Wetmore, was an unusually carefully prepared and finely illustrated paper. Many of the methods of treating this accident were alluded to. Only two, however, were described minutely and endorsed by him, of which we append the following synopsis:

After a few well chosen remarks by the writer, he proceeded to demonstrate first the method introduced by Dr. E. M. Moore, of Rochester, N. Y., having a student on which to adjust the dressings. As the literature of clavicular fractures is replete with a multiplicity of appliances having for their object the restoration, co-aptation, and retention of the fragments during the process of repair. Surgeons, during the last half century, have very closely followed the teaching of the old masters; but to introduce the most effective, simple, practical and satisfactory retentive measures is accredited to men of our day.

Causes.—After discussing how fractures of the clavicle are most frequently produced, describing the solution of continuity, etc., etc., he thus continued: If the fracture is complete, the shoulder is depressed and drawn forward by the action of

the pectoral muscles, while the inner portion of sternal fragment is salient, and sometimes perforates the tissues sufficiently to constitute a compound fracture, though happily, this complication rarely occurs. To better comprehend the obstacles with which we have to contend, the reader should be familiar with the origin, insertion and action of the great pectoral and sterno-cleido-mastoid muscles. The peculiarity of the pectoralis major is, that its upper fibers become undermost at its insertion, and its under fibers become uppermost.* That the clavicular fibers of this muscle are direct antagonists of the sterno-cleido-mastoid, and the further the humerus is carried backward, the greater the tension of these fibres, and the more perfect the restoration of the fragments. The elbow figure-eight bandage meets all the requirements in a simple fracture of the clavicle in the middle third, the one we will take under consideration, and by using a shawl or piece of cotton cloth or muslin, folded like a "string neck-tie" or cravat; it should be eight inches in breadth; this should be about two yards long. Placing this wide folded bandage across the palm of the surgeon's hand, the surgeon then seizes with this hand the elbow of the patient which corresponds with the broken clavicle, the two ends of the bandage hang to the floor, the one falling inward towards the patient is carried upward in front of the shoulder and over the back, making a spiral movement in front of the shoulder. This is entrusted to an assistant; the outer end is then carried across the forearm, behind the back, over the opposite shoulder, and around the axilla. This meets the other end, which may be carried under the axilla, and over the shoulder of the opposite side, thus making the figure-eight turn around the sound shoulder.† Continuing the description, this twist, it will be seen, makes also the figure eight turn around the elbow of the affected side. The forearm should be sustained by a sling, which raises it to an acute angle, in order that gravity may assist in moving the whole arm backward. This is best done by a simple strip three or four inches wide, which may be pinned to the fabric or bandage at the shoulder, or by a sling across the opposite shoulder and behind the back. It will be observed that the bandage as it passes in front of the arm does not press on the axillary border of the pectoral muscle and therefore avoids the objection of the ordinary figure-eight.

The writer has treated a number of cases during the past ten years by this method with no unsatisfactory result, and heartily commends it to the profession. Its advantages are:

1. The apparatus is readily obtained and found in every well-regulated household.
2. It can be applied over the ordinary clothing.
3. It is readjusted easily when it becomes disarranged.
4. Any attendant can be instructed so as to readily keep it in place.

* See any work on surgical anatomy where a dissection of these two muscles is illustrated.—L. H. M.

† The reader can easily follow the description herein stated, by the adjustment of a shawl or a piece of muslin eight inches in width, so that when it is folded upon itself it will be four inches wide, then apply it to any member of his household, over the subject's clothing.—L. H. M.

The next method we will describe is that of Dr. Louis A. Sayre, of New York city, who treats fractures of the clavicle upon the same principle, viz., putting the clavicular portion of the pectoralis major muscle on the stretch, and compelling it to pull the clavicle in place by means of adhesive plaster cut in two strips three or four inches wide (for an adult), one piece long enough to surround the arm and go completely around the body, the other to reach from the sound shoulder around the elbow of the fractured side and back to the place of starting. The first piece is passed around the arm just below the axillary margin, and pinned or stitched in the form of a loop sufficiently large to prevent strangulation, leaving a portion on the back encased by the plaster. The arm is then drawn downward and backward, until the clavicular portion of the pectoralis major is put sufficiently on the stretch to overcome the sterno-cleido mastoid, and thus pull the inner portion of the clavicle down to its level. The plaster is then carried smoothly and completely around the body and secured with a safety-pin to itself on the back to prevent slipping.* The first strip of plaster fulfils a double purpose, first by putting the clavicular portion of the pectoralis major muscle on the stretch, it prevents the clavicle from riding upward; and secondly, acting as a fulcrum at the centre of the arm when the elbow is pressed downward, forward, and inward, it necessarily forces the outer extremity of the humerus (and with it the shoulder) upward, outward, and backward. It is kept in this position by the second strip of plaster, which is applied as follows: commencing on the front of the shoulder of the sound side drawing it smoothly and diagonally across the back of the elbow of the fractured side where a slit is made in its middle to receive the projecting olecranon.

Before applying this plaster to the elbow an assistant should press the elbow well forward and inward, and retain it there while plaster is continued over the elbow and forearm, pressing the latter close to the chest, and securing the hand near the opposite nipple, crossing the shoulder at the place of beginning; it is there secured by two or three safety-pins. When this has been done, the deformity will have entirely disappeared, the fractured bone will be accurately adjusted, and as long as the strips of plaster maintain their position, no amount of force can displace them. It will thus appear obvious to any one interested in the treatment of this most interesting lesion that the key to its successful management is in making the clavicular fibres of the great pectoral muscle tense, and keeping them so during the period required for repair. No method can be successful if the humerus be allowed to maintain a perpendicular position. The plaster method of retention has some advantages over the "neck-tie" or cravat mode. It is evidently the more secure, firm, and unyielding, at first (very desirable qualities, particularly with children) and the patient presents a more comely appearance when dressed. Its disadvantages are: The surgeon, and particularly the country practitioner, does

* The same rule may apply in this as in the first description by adjusting a bandage to any member of the house to enable the reader to more readily understand the dressing.—L. H. M.

not always have with him the plaster; in hot weather the plaster is apt to excoriate and become irksome and unpleasant; again, if sufficient traction be made upon the humerus to be of utility as a lever, it necessarily becomes tedious to bear, and the patient tires of the constant strain. * * The writer did not feel qualified to criticise very closely the plaster method, each of the two modes herein described have been before the profession for several years. It is to keep before the medical world those remedial measures which the writer's experience has proven to be the most perfect in its results that the subject is brought forth, although not as advancing anything new, which however, should the discussion advance any more modern and better means, he and all of us would gladly apprehend. The paper elicited a free discussion, which was participated in by many of the members. Their views set forth may be found as under.

Dr. R. W. Bishop mentioned a case of double fracture of the clavicle that he had recently been called to attend. Upon examination there was found a three-cornered piece of the bone splintered off, that was wedge-shaped, and "turned up" edgewise under the skin, and any method that he devised failed to retain this fragment in position. The case is improving, however, but still under treatment.

Dr. C. E. Webster, whilst visiting Bellevue Hospital last year, upon the invitation of an interne, who is a personal friend, had his attention directed to a number of cases of fracture of the clavicle, and their mode of dressing, none of whom, he thinks, were applied according to Sayre's method. Upon inquiry, I was informed that usually that method was adopted if a patient was first treated in the clinical department, for it was more artistic than any other; but it would soon become loose, and it also excoriated the surface, and the plan devised afterwards for dressing the fracture is similar to that which are doubtless seen frequently by physicians.

Dr. W. L. Axford had listened with great interest to the instructions set forth in the paper on this topic. With the solution of continuity that occurs at the middle or outer third of fracture of this bone there is also deformity of the acromial or sternal fragments, or of both. To treat this, we must raise the outer or acromial end and lower the sternal end, especially the former must be done. So many methods are recommended for treating these cases, that any of them are axiomatic, and the case will pursue its own course until there is recovery. He is therefore skeptical of any of the ways as being superior to any other mode. He desired to ask the author if no deformity resulted in the cases he has treated by the methods he has endorsed?

Dr. A. B. Strong: Regarding the anatomy of the muscles of the clavicular region, nothing has been stated in the paper that the sub clavias and dense fascia play any part towards adding to the deformity, which I think is true, for this little muscle is excited to contraction, or is irritated, and so to is the dense fascia, as a result of the fracture, relative to the treatment, he thinks to place the arm in a simple sling and have the patient lie on a hard mattress, that as good results will occur; and this he thinks is really the best possible

known method. He was much pleased with the paper, as he had not heard of nor had he ever seen the dressing applied before, that the author has so ably commended.

The Chairman. I saw the case with Dr. Bishop, that he has cited; the fracture was comminuted, and there was a tilted edge of spicula of bone that could not be retained in its place. The method spoken of by the writer is not unlike what is called here Dr. R. N. Isham's method, *i. e.* by making a hitching-post of the sound shoulder and begin here to apply a bandage, and form a double figure-eight. It gives as good results as any unless it be a plaster Paris dressing; this, however, is irksome and difficult to apply to little children. His success and experience is that deformity will result, no difference what plan is adopted. The let alone plan often times will do, and nature will give an admirable result; he has long ago discarded the use of the plaster method. A bandage secured to a tight-fitting knitted shirt is another very good way to retain a fracture in its place.

Dr. L. H. Montgomery inquired of the author if a case was presented to him that was similar to the comminuted fracture cited here, where the fracture is oblique, as they always are, which of the methods would he apply, that he has offered? And would it not be necessary to apply also a compress over the seat of injury? My experience in treating these cases is, that all have recovered, so far as I know. Two, without deformity, one of which was the so called "green-stick" fracture, occurring to a little boy 6 or 7 years old. The other case being that of a young man eighteen years old, a clerk, who was anxious that no deformity should result. I told him the only possible method to avert this would be for him to lie on a pretty firm or hard mattress for three weeks, after I dressed the broken clavicle by bandages, and a small bag of sand applied over the seat of the fracture for a compress. This he did for about that length of time, and to our great satisfaction, a perfect result was obtained. I think a compress of this kind is valuable if we can persuade a patient to remain quiet, especially if the patient is a female who is particularly desirous of no deformity.

Dr. W. H. Curtis thinks great caution should be taken to avoid compressing the brachial artery in applying a bandage or plaster dressing tightly around the arm, especially if the surgeon can not be had quickly. Should swelling supervene, the patient and friends should be on the alert for this, which if it occurs the bandage should be loosened and readjusted.

Dr. Wetmore replied serially, first to Dr. Axford, by stating that he had treated a number of cases of this fracture in female children and adults, and no deformity resulted. In strong, athletic men he recalled more than one instance also where by the Moore method of treatment perfect recovery resulted. Twenty-five years ago, he saw his preceptor treat a case of this kind by having the man lie upon a bolster to get the weight of the shoulder to pull back the clavicle. The man recovered with no deformity. In the case of comminuted fracture that has been cited and inquired about, I think a compress applied as Moore's method carried out would be the most judicious dressing.

The next paper was a very comprehensive one on "Rhinolithiasis," by Dr. Jefferson Bettman, of which our reporter has furnished a short abstract, and given the principal points of a case of this rare form of difficulty.

Report of a Case of Rhinolithiasis of Supposed Forty Years' Development.

The comparative rarity of this affection, and the interesting features connected therewith, warrant our giving a synopsis of the following case:

Status præsens.—The patient, æt. 49, consulted the author in June, 1884, for what he termed "chronic catarrh of the head," extending over a period of many years. Of late, the annoying symptoms had been more aggravating. The nasal discharge was so copious as to necessitate a daily use of from four to six handkerchiefs. Periodical attacks of hemicrania extending over the right orbital and temporal regions also complicated the case. Marked obstruction on the right side of nasal respiration. Physically he is of goodly dimensions, well-proportioned, a picture of florid health. External nose appeared congested and slightly tumefied, borders of the nostrils somewhat excoriated. Introduction of the nasal speculum occasions violent attacks of sneezing. This exquisite hyper-sensibility of the mucous membrane quite precluded a thorough examination of the nares. There was limited fetor in the expired breath, yet sufficient as to be imparted to the nasal secretion. This was viscid, slightly flocculent, and filled both nostrils, necessitating removal ere permitting a survey of the parts. Illuminating the nares, a marked vascularity and thickening of the mucous membrane was noticeable. The tissues covering the inferior turbinated bones were so thickened as to encroach upon and nearly obliterate the fissura respiratoria.

The mucous membrane covering the septum presented almost a fungoid appearance; both middle turbinated bones were enlarged so as to press upon the septum. The posterior half of the right nasal fossa was filled with an accumulation of creamy-looking discharge, and attempts at its removal by a well-directed stream of tepid water were futile. The nasal lumen was so narrowed and encroached upon by the hypertrophied turbinated bone and a co-existing deflection of the septum, that it was with difficulty a cotton-wrapped probe could be guided through the parts that were so sensitive. Palpation revealed the presence of a hard grating substance occupying the floor of the right nasal fossa, which was supposed to be necrosed bone as a result of a constitutional dyscrasia. Thorough inquiry elicited negative replies in this direction. To allay the morbid sensibility of the parts, a detergent nasal lotion was advised to be used *ad interim*. In two days this proved effective, for the hyper-sensibility and tumefied mucous membrane were markedly improved. Under a strong illumination, the position of the foreign body was then defined. Lying on the floor of the nasal fossa in its posterior half, it seemed to be impacted between the bony septum and inferior turbinated bone. The exposed surface of body was rough, uneven, unyielding to the touch of the probe. To dislodge and remove it, a pair of strong aural forceps, bent at right angles, were used. A firm resistance was made upon traction. The fauces, too, were uncontrollably

irritable, defeating all attempts at posterior rhinoscopy. The size of the body had undoubtedly been underestimated. Its removal in toto anteriorly was impossible, on account of the narrowed lumen of the nasal passage. Attempts at removing it piecemeal were but partially successful, after repeated trials. The feasibility of removing it through the naso-pharyngeal space presented itself. Cautioning the patient not to inspire deeply, or swallow, while the operator guarded the faucial orifice, the foreign substance was then forced into the naso-pharyngeal space, and in a moment the gentleman spat it out. Darkish-gray, almost black in color, conoidal in shape, and from which a disagreeable fetor emanated, its weight, firm consistency, and the pebble-like uniformity of its unexposed surfaces, were sufficient to indicate its calcareous condition. Irregular in shape, the contour of the concretion conformed to the confines of the surrounding tissues. Its medial surface measured one and a half centimeter in length, by one and a quarter centimeter in breadth; the inferior surface one and a half by one-half centimeter. The exact weight was one and a half grains. Embedded in the mass was a cherry-stone. Incidents of the patient's early childhood were vividly impressed upon his memory, but in no possible manner could the presence of the cherry-stone be accounted for. Free nasal respiration was fully restored, and great relief followed. Subsequently, however, a small mucous polyp, high up in the same nostril under cover, and almost hidden by the middle turbinated bone, was discovered, which was easily removed.

The literature on the subject of rhinolithiasis was then carefully reviewed by the writer minutely. Stork avers that he has seen but one example of it, and no mention of it is made in many works on general surgery. The term was first applied by Demarquay, and our French confrères describe the greater number of cases. Demarquay and Poincot have written brochures on this subject. The determining cause is the presence of a foreign body, which forms a nucleus for the deposition of lime salts. Nasal concretions have, however, developed independently, and were not due to the presence of any extraneous substance, congenital or acquired atresia. Stenoses of the nasal lumen favor the retention, and subsequent desiccation of nasal secretion, and by a nidus, cause a concretion. A gouty diathesis may also be a predisposing cause. Virchow describes a "diathesis ossifica" as a cause, which, by the way, is an entirely different process, however, somewhat like the subject under discussion. During an act of vomiting or retching, undigested particles of food which may be forced through the naso-pharyngeal space and lodge in the posterior nares, may be the nidus. Barring this possibility in the foregoing case, the concretion may be presumed to have been of more than forty years' development. Jacquemart lately described a case where the trouble existed over twenty years.

Multiple rhinoliths have been found in rare instances. Their concentric disposition was next described by the writer, which consumed considerable space; also their chemical composition.

The symptoms incited by their presence are frequently not marked, and hence they are doubtless often overlooked. The rhinorrhœa being regarded

and treated as a catarrhal congestion of the tissues, which may often result in epistaxis, "the chronic vascularity induces a state of hyper-nutrition and cellular activity in the surrounding tissues, favoring redundancy and neoplastic changes."—(Billroth.)

Hemicrania or nervous headache is a noteworthy symptom that is present in many cases. "This may be periodical—and checked by spontaneous expulsion of minute concretions."—(Axmann.) Also, other "reflex neuroses may be present."—(Hack.) The dental drill might render signal service. Posterior rhinoscopy occasionally renders valuable service in their detection. In Jacquemart's case, already alluded to, himself and more than ten consultants had made a previous diagnosis of osteo-sarcoma. A few cases are on record in which rhinoliths were expelled spontaneously where the concretions were very small. A stream of hot water injected through the opposite nostril may in some cases prove effective in dislodging the concretion. "Sternanotatories may be worthy of trial."—(Frankel.) In post-nasal extraction of a calculus, strict precautions must be adopted to prevent it from falling into the larynx.

The remainder of the paper consisted in the laudation of modern nasal surgery, which has assumed a dignified position in the scientific field, but, as the writer justly stated, it is doubtful

whether any part of the body is dealt with in so slipshod and culpable a manner as the *naso-pharyngeal cavity*, and the humane precautions so often neglected in treating nasal disease, on part of both patient and surgeon.

DISCUSSION.

Dr. F. O. Stockton stated that one simple method the essayist had omitted to state in his paper—it was of strong pressure through the posterior nares, to expel the calculus by the anterior nares. Do not close the opposite nostril, while essaying to do this, which is far preferable to any other mode, when it can be done. Another way is by a simple loop of iron wire passed about the stone, then, by rotating it about the stone, extract it anteriorly. He cited a case that came under his care whilst he was in London—that of an English gentleman having a rhinolith, where it had absorbed and passed through some of the small bones of the face. His method of extracting it was by using an engine with a diamond-pointed drill. A hole was drilled in different directions in the stone, and thus it was removed piece-meal. He knew of no other case being operated on in this manner. The engine is the invention of Dr. Goodwillie, of Philadelphia, and used by him in dentistry.

At a late hour, the Society then adjourned.

L. H. M.

EDITORIAL DEPARTMENT.

PERISCOPE.

The Staining of Koch's Bacilli.

The *Med. News*, May 1, 1884, says: So much has been written and printed since Koch's original publication, upon the treatment of tubercle-bacilli with a view to their better and easier demonstration, that a systematic article by Fränkel, published in full in the *Berliner klin. Wochenschrift* for March 31, will be welcomed by physicians, especially as the methods are intended to be employed in the office rather than in laboratories.

In general, it may be said of the bacillus tuberculosis that it imbibes only certain aniline coloring matters; that a certain period of exposure is necessary; and that it must be treated by certain additional fluids to secure the most distinct demonstrations.

After a comparative trial of twenty aniline colors, Fränkel concludes, with other investigators, that the best are, undoubtedly, methyl-violet and fuchsin. Both of these are hydrochloric acid combinations, and both stain animal fibres more easily than vegetable. As to the time required for staining, ten minutes are necessary at the temperature of the room, although a much shorter time suffices in the warm box, while Rindfleisch has also shown that by warming the fluid the staining may be made instantaneously.

With the added fluids, Fränkel found the aniline water, as first suggested by Ehrlich, to give

the best results, although equally good results were obtained with toluidin water, an analogous substance which is always found to accompany the commercial aniline as an impurity. A durable fluid is composed of 93 c.c. of water, 3 c.c. of aniline oil, and 6 c.c. of alcohol. In this aniline water the coloring matters may be dissolved, but it is better to have on hand alcoholic solutions of fuchsin and methyl-violet, and before using to add, by means of a dropper, as Ehrlich originally suggested, as much of the solution of coloring matter as will produce a decided opalescence in the fluid. Five cubic centimetres of aniline water are heated to boiling in a test-tube, poured into a watch-glass, and the concentrated solution of coloring matter added. Upon this the covering-glass, on which the sputum is smeared, and dried by passing it a few times over the flame of an alcohol lamp, is floated for from two to five minutes.

In order to demonstrate the bacillus more distinctly, acids, alcohol, and watery solutions of other aniline colors are used, either to decolorize the other elements of the sputum, cells, nuclei, other fungi, or foreign substances, or so to stain them by these colors as to put them in contrast with the stained bacilli. For this purpose, Ehrlich uses nitric acid diluted three times; Petri, glacial acetic acid; Rindfleisch, feebly-acidulated alcohol; and Koch, in the beginning, vesuvius-solution.

Fränkel regards it as especially important to re-stain the decolorized preparation, thereby elim-

inating all possibility of a mistake. For this purpose he has recently used a mixture of 50 parts of alcohol, 30 of water, and 20 of nitric acid, which is saturated with ethylene blue, and then filtered. Into some of this fluid, the preparation is carried directly from the first color solution, and in this way the decolorization and second staining are at once accomplished, an immersion of one minute sufficing. The sputum on the cover-glass is then washed in water or in 50 per cent. of alcohol acidulated with one per cent. of acetic acid, and well dried by first compressing between filtering paper, and then quickly passing through a flame. In this way, says Fränkel, a preparation can be completely made and doubly stained in four minutes.

Baumgarten's method of demonstrating the bacillus unstained is less satisfactory. By Gibbs's method of staining the bacilli red and the background blue, by a single fluid, Fränkel thinks fewer bacilli are brought out than by the one detailed.

As to the use of an immersion system and Abbe's illuminator, Fränkel says that much time is saved by them; but that with a good Hartnack No. 7, or any corresponding power, and ordinary illumination, the bacilli are easily recognized.

Compensatory Hypertrophy.

Before the Medical Society of London (*Lancet*, April 12, 1884): Dr. Joseph Coats (Glasgow) read a paper dealing systematically with hypertrophy of the various organs. In some preliminary remarks he observed that it was necessary to bear in mind the difference between hypertrophy and hyperplasia, though it was not possible to carry the distinction into practice. Practically it was sufficiently accurate if under the term hypertrophy we included all forms of increase in the quantity of functionally active tissue of an organ, whether this was due to numerical increase of the elements of the tissue or to an increase in the bulk of the individual elements. Compensatory hypertrophy occurred most readily during the period of growth; the causes by which it was produced were of two classes—excessive performance of normal function, and destruction of portions of tissue resulting in overgrowth of the remaining portions. After referring to hypertrophy of the heart, bladder, and various parts of the alimentary canal, he discussed at length the occurrence of hypertrophy of one kidney after the removal of the other, quoting the experiments and conclusions of Rosenstein, Grawitz, Israel, and Gooden, and relating some observations of his own. The general results of these researches seemed to establish that the glomeruli were not increased in number, and not greatly in size (the increase being in the proportion of 41 to 30 or 8 to 5, according to various observers), but the enlargement was chiefly due to an increase in the thickness and bulk of the epithelium, but chiefly to increased length, and therefore increased convolution of the tubules. This, he thought, went to support the theory that the convoluted tubules discharged the most important functions of the kidney. In dealing with the subject of hypertrophy of the lungs, he quoted the researches of Dr. Theodore Williams, and detailed a case of

vicarious hypertrophy of one lung from defective development of the other. After a full discussion of this subject, in which he observed that compensatory hypertrophy rarely occurred in phthisis, probably owing to the general depression of nutrition, he shortly referred to the occurrence of hypertrophy of the liver secondary to destructive disease, and observed that it was due to enlargement of the lobules from multiplication of the hepatic cells.—Dr. Douglas Powell differed from the author in respect of compensatory hypertrophy, as it was seen in phthisis; he considered that in such cases hypertrophy could occur. No doubt in some instances the lung remaining did not become hypertrophied but only dilated, and then the patient was breathless and weak. Hypertrophy of organs beset us in all directions. Instances in the heart and stomach were mentioned.—Dr. Fancourt Barnes spoke of the hypertrophy of the heart in pregnancy as a typical example of physiological compensatory hypertrophy.—Dr. Kingston Fowler alluded to cases of hypertrophy and dilatation of the ascending colon associated with ulceration, but no obstruction. Was there general cirrhosis in the case of syphilitic hepatic disease?—Dr. Joseph Coats, in reply, thought that he had admitted in the paper the possibility of the occurrence of compensatory hypertrophy in cases of chronic phthisis. In diabetes insipidus he considered that all the secretory structures were at work, and so tended to become hypertrophied. There was no general cirrhosis in the instance of syphilitic disease of the liver which he had mentioned. He had no experience of cardiac hypertrophy in pregnancy, but regarded the line between physiology and pathology as by no means a hard-and-fast one.

Ipecacuanha in Large Non-Emetic Doses in the Treatment of Cholera.

The *Med. Times*, August 9, 1884, says:

Among the numerous plans of treatment that have been recommended or actually adopted in the treatment of true or Asiatic cholera, there is none that, from past experience, seems more deserving of a faithful extended trial than that by ipecacuanha, as presented to the profession with such force and ability by Surgeon A. A. Woodhull, U. S. A.* The method of treatment of dysentery which was advocated by the author, by "large non-emetic doses," has become widely known and is generally practiced, but the fact seems not to have been properly appreciated that he also insisted upon the possible value of this method of treatment in Asiatic cholera, the full title of his essay being "Clinical Studies with Large Non-Emetic Doses of Ipecacuanha, with a Contribution to the Therapeutics of Cholera." Without attempting an analysis of this valuable paper, we merely repeat the caution of the author, who especially enjoins upon those who adopt the treatment in their practice to adhere to the non-emetic method. Large doses, from a scruple to a drachm of the powdered root, may be given without disturbing the stomach, if the patient remain quietly in the recumbent posture after its admin-

*In a report to the Surgeon-General in October, 1874, which afterwards appeared in full in the *Atlanta Medical and Surgical Journal*.

istration and abstain for a time from drinking fluids. Very often, however, it is necessary to insure the desired result by the preliminary administration of a full dose of ipecacuanha. The strikingly favorable results thus obtained by the administration of ipecacuanha in dysentery, in hemorrhage, and in collapse, would certainly warrant the further extension of this treatment to analogous conditions occurring in the course of cholera. Nor is the recommendation for its employment in cholera without support from clinical experience. M. Bourdon, in the wards of La Charité, has used it with decided success in the treatment of cholera infantum, which so closely resembles the true cholera. In fact, it was reported by M. Decugis (mentioned by Woodhull) that at the first appearance of the cholera in 1832, the physicians, struck by its resemblance to dysentery, proposed ipecac, and it was even considered a specific for cholera by Grisolle; but further experience taught that, when used in the ordinary way, it was of slight utility, and this opinion is generally echoed by our text-books.

The treatment of Dr. Woodhull is, on the contrary, based upon the effects of ipecacuanha when administered in a very different manner, in large non-emetic doses, in which it acts as a sedative, as pointed out by Waring, who also recommended its use in cholera.

A Monstrosity.

Dr. J. H. Gardiner, in the *Canadian Practitioner*, May, 1884, says:

"I have in my possession a remarkable specimen of monstrosity, consisting of a child with two heads, complete and well formed in every respect.

"The mother was in the ninth month of gestation, when labor pains commenced, and the labor did not last more than three hours. She is the mother of four children, all healthy and well formed; both father and mother are healthy. Pulsation continued in head last born, and in body, for more than twenty minutes after birth, and an attempt was made to set up respiration, but it was only partially successful. The head first delivered never showed any signs of life after complete delivery, being very much congested at birth. One hour elapsed between delivery of first and second head.

"There was one cord and one placenta.

"The specimen weighed eleven pounds at birth.

"There was a complete separation of necks down to shoulders, and separate spinal columns to termini.

"The upper extremities are well formed and two in number.

"The lower extremities are deformed, talipes varus existing in all. There are three legs, two in the usual position, and one over right ilium. This third leg is most deformed of all, being smaller and more like a wing without feathers than a leg; there are six toes on it. Two anal canals exist, but the genital organs are of the usual appearance of those of a healthy male child.

"The mother did not complain of any unusual

sensations, impressions, or longings, during gestation, nor had she any fright. Now, the question is, how did such a monstrosity have an existence? Evidently twins were designed by nature, and from some peculiar placing of the double ova in early fetal life, a blending of the parts resulted. The external blastodermic membranes have suffered less than the middle and internal; but I must leave to more skillful physiologists and embryologists to explain this medley on the part of nature. (It reminds me of Dr. Richardson's chicken without the feathers.)"

REVIEWS AND BOOK NOTICES.

NOTES ON CURRENT MEDICAL LITERATURE.

—In a reprint from the *American Practitioner*, Dr. N. B. Cook relates the recovery of a patient who had swallowed two drachms of extract of cannabis indica. In the course of his article he makes the following general remark: "From my experience in the treatment of poisoning from narcotics, if all the remedies recommended were placed before me and I was obliged to select and rely on one only, I would unhesitatingly choose the battery. I would rely on it with more confidence in a good result than all others combined; premising, however, the use of emetics or stomach-pump in cases seen before the poison had all been absorbed."

—The Illinois State Board of Health has issued a circular to all mayors or presidents of village boards of health, recommending that they pay especial attention during the summer months to the following points of public hygiene:

First—The condition of the water supply.

Second—The disposition of night-soil, garbage, and sewage.

Third—The cleansing of streets, alleys, and other public places.

Fourth—The supervision of food supplies, and of market-places, slaughter-houses, and similar establishments.

Fifth—The general sanitation of every house and its surroundings.

—The "Proceedings of the First Three Meetings of the Surgeons of the E. Division of the W., St. L. and P. Railway" (Fort Wayne, Ind.), makes a neat pamphlet of 116 pp., containing a number of original articles of value to surgeons in general, and railroad surgeons in particular. Such a publication is a proof of the enlightened activity of the American profession, and the thoroughness with which it pursues special scientific inquiries.

—The address of Dr. L. Woodruff, of Alton, Ohio, before the Alumni Association of Starling Medical College, is a sensible and well-prepared paper on the relations of medicine to the general public.

—The question of quarantine is discussed temperately in a pamphlet, "Quarantine and Commerce: How to Enforce the One without Detriment to the Other," by Dr. Joseph Holt, President of the Board of Health of Louisiana.

—Dr. Rollin R. Gregg, of Buffalo, New York, sends us one of his novel studies entitled "The Revelations of Fibrin; Unexpected Proof of the Immortality of Life." We fear his experiments will not engage the attention he asks for them.

—The Second Part of Lloyd's Quarterly, "Drugs and Medicines of North America," treats of the Hepatica and Ranunculus. It is well printed and illustrated, and in time must prove a useful book.

—Dr. J. H. Voje, of Fredonia, N. Y., favors us with a copy of his inaugural dissertation on receiving his degree of M. D., at Leipzig. It is entitled "Ueber die Ursachen des sogenannten Puerperal Fiebers," and is a careful thesis.

BOOK NOTICES.

Diseases of the Throat and Nose. Including the Pharynx, Larynx, Trachea, Oesophagus, Nasal Cavities, Naso-Pharynx, etc. By Morell Mackenzie, M. D., London, Consulting, late Senior Physician to the Hospital for Diseases of the Chest and Throat. Vol. II. Philadelphia, P. Blakiston, Son & Co. (Price, 2 vols., cloth, \$6.00.)

Dr. Mackenzie has long been considered the leading English authority on nasal and pharyngeal diseases, and this work may justly be considered the summary of his experience and his observations. He tells us that every page has been written and re-written to bring it up to what he considered the proper form, but that even yet he does not reach the ideal he had set for himself. Few place their ideals so high, and fewer are so frank about their endeavors to reach it. Not many readers will perceive where it falls short. Certainly no more complete treatise on the subject is to be found in any language. It will be sufficient to give an idea of the scope of the work, to give a short abstract of its contents:

The Gullet—Anatomy, Examination, Oesophageal Instruments, Diseases, Acute Oesophagitis,

Phlegmonous Oesophagitis, Ulcer, Varicose Veins of the Gullet, Malignant Tumors of the Gullet, Non-Malignant Tumors, Syphilis of the Gullet, Dilatations, Rupture, Wounds, Foreign Bodies, Oesophagotomy, Spasm of the Oesophagus, Post-mortem Softening of the Gullet.

The Nose—Anatomy. Rhinoscopy, Nasal Instruments, Acute Nasal Catarrh, Purulent Nasal Catarrh, Hay Fever, Chronic Nasal Catarrh, Chronic Blennorrhoea of the Nose and Air-Passages, Bleeding from the Nose, Tumors, Fibrous Polypi, Malignant Tumors, Syphilitic Affections, Glanders, Affections of the Nose in Eruptive Fevers and other Acute Diseases, Fractures of the Nose, Dislocation of the Nasal Bones, Foreign Bodies in the Nose, Congenital Deformities of the Nose.

The Naso-Pharynx—Chronic Catarrh of the Naso-Pharynx, Dry Catarrh of the Naso-Pharynx, Fibrous Polypi of the Naso-Pharynx, Malignant Tumors, Throat Deafness.

Appendix—Special Formula for Topical Remedies, Nasal Washes, Nasal Sprays, Gossypia Medicata, Olfactoria, Snuffs.

It will be seen that the field is well covered in this volume.

Transactions of the Mississippi State Medical Association, 1884. 8vo., pp. 190.

Quite a number of interesting articles fill this volume, dealing with practice, surgery, obstetrics, and hygiene. While a portion of them are local in character, the greater number will have a general interest for the profession at large, and will merit preservation in print.

The Formation of Poisons by Micro-Organisms.

A Biological Study of the Germ Theory of Disease. By G. V. Black, M. D., D. D. S. 1 vol., pp. 178. Price \$1.50. P. Blakiston, Son & Co., Philadelphia.

Many readers would like a clear historical and scientific sketch of the "germ theory," what it means, who started it, what there is to be said for it, what may be its applications in medicine and hygiene. They will find such a sketch in this volume, by a writer who has evidently kept himself acquainted with the progress of the discussion, and who writes without any undue bias for or against, and with an appreciation of what the laws of evidence demand. We do not doubt the essay will prove a satisfactory one to readers, and we recommend it to their attention.

—In the *Edinburgh Med. Jour.*, Aug. 1884, Dr. C. Clark Burman reports a case of abdominal wound, with protrusion and wound of small intestine, the result of a stab. Recovery.

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OCEAN-BATHING.

"If I were to go in the ocean and bathe for half an hour, my pulse would drop from eighty down to forty-five beats a minute." "I feel dreadfully to-day; I remained in the ocean more than an hour, and when I reached my bath-house, I was too much exhausted to dress and felt like lying down and going to sleep." "I had a very peculiar case to-day; a robust young man went in to bathe, and when he came out, laid down in his drawers and undershirt to rest, with two windows open and a current of air blowing over him; in a few minutes he had a violent chill, followed by a raging fever."

These three remarks, overheard within an hour, the other day, are but samples of what one hears every day at our sea-shore resorts. From them it may be inferred that ocean-bathing is not an unalloyed benefit to all persons. Some are so constituted, as the man with the susceptible pulse, that the bath ought to be absolutely interdicted, while with others the evil results are directly traceable to the ignorance or carelessness of the individual. There are very few persons who bathe as they should. The vast majority remain in the water too long, many battling with the breakers for more than a hour, while it is the exception to find a person who remains in less than three-quarters of an hour. One who has never been in the ocean, can form no conception of the amount of force expended in diving into or even standing up against the powerful breakers, involving as it does an amount of labor, of muscular exercise, that would soon produce fatigue, were the surroundings less stimulating and exciting. Again, it is not an uncommon sight to see young men and women, after bathing for half an hour or so, come out of the water and sit on the beach, talking to friends, while the air is rapidly evaporating the water from their persons, and their chattering teeth, livid lips, and shaking bodies, give plain evidence that they are being thoroughly chilled. Then off again they rush into the water, to still further exhaust themselves. A distinguished English physician has said in the *Lancet*, that he believes that if we were to examine the

urine of every person coming out of an ocean bath, in the majority of cases we would find albumen, thus evidencing a temporary congestion, which of course is increased by this exposure and evaporation on the beach. How much better would it be to walk briskly to the bath-house, and disrobing, rub the surface well with coarse towels until a tingling, glowing sensation gives evidence of a re-establishment of the cutaneous circulation! Some young ladies, (though we are glad to say the number is small) are so infatuated with the bath that they will not forego it, even during the menstrual period; that this is wrong, needs no arguments to prove; and still further, some pregnant women actually go in to bathe, and we are not surprised to hear that abortion occasionally results. If a healthy person, not endowed with any idiosyncrasy, which experience indicates as forbidding the bath, will stand about in his bathing clothes until well cooled off (but not long enough to feel chilly) and then go into the ocean for fifteen minutes, keeping the body well immersed all the time, and then rub himself well into a glow, we feel sure that the bath will prove to him an unalloyed benefit, and that he will return from the sea-shore invigorated and benefited by his sojourn there.

MILK DIET.

The recommendation of men distinguished for their talents and with world-wide reputations, has had the usual result with the milk diet question that we are wont to note with all other questions—namely, that the masses, following blindly the few leaders, have gone to the extreme; and we see daily, in the secular press, items to the effect that so-and-so (mentioning some distinguished person) is on the milk diet, and it is generally added that his complaint is Bright's disease. Thus these accumulating reports lend still more popularity to the diet, until in the minds of many persons Bright's disease and milk diet have come to hold a most wonderfully intimate relationship, the one with the other.

That milk is an exceedingly nutritious and

easily digested article of diet no one questions, but that it has any *specific* action in Bright's disease seems to us, to say the least, very problematical; while on the other hand, such-a restricted diet, serving as a constant reminder to the patient of his malady, would have the effect in many cases of causing the invalid to brood over his incurable disease, and thus by disturbing his equanimity and distressing his mind, would, we fear, have an injurious influence on the progress of the disease. A very distinguished physician in this city, places great faith in milk diet in this and other chronic diseases; and so firmly does he seem to believe in its efficacy, that even though it may sicken the stomach and constipate the bowels, as it not infrequently does at first, he still persists in its use, ordering his patient to bed, and commencing, may be, with teaspoonful doses of milk, with lime water, keeps the patient on his back until the milk ceases to produce these disturbing effects, and can be taken with impunity. But while this process of gradual accommodation may remove some of the objections to an absolute milk diet, it will not do away with the introspective objection which we have urged—it will not prevent the patient from brooding on his disease, and thus helping its progress. It is a fact that we have frequently observed in Bright's, as in other diseases, and it is a fact familiar to all physicians, that in those who are blessed with a buoyant, happy, "easy-going" disposition, who seem to forget (unless reminded of it) that they are afflicted with an organic and incurable disease, the disease seems to make comparatively little progress. We are all familiar with the evil influence of "worry," and of too much concentration of thought upon self and upon one's weaknesses. And from this fact we must perforce draw the logical lesson that we should never advise that which is calculated to cause worry and introspection. Hence, while we recognize the value of milk diet, yet we think that before directing it we should carefully study the temperament and disposition of our patient. To the sanguine, "easy-going," it will, in the majority

of instances, prove an unalloyed boon; while to the nervous, irritable, introspective, and "worrying" patient, it would seem more prudent to recommend the free use of milk, but not to enjoin the absolute, restricted milk diet.

LIFE AT THE SEA-SHORE.

Dr. Busey, of Washington, was offered the opportunity last summer at one of our fashionable resorts, of studying the evil influence of the constant use of high-heeled French shoes upon the female form, and this year we have been favored with the facilities for observing the methods of life pursued at the sea-shore. Without croaking or moralizing or fault-finding, we are compelled, in justice to our convictions, to assert that to the majority of persons a sojourn at the sea-shore is not calculated to prove so beneficial to health as the natural advantages and the intentions of the visitor would seem to warrant. There are two classes of persons who visit the sea-shore: those who go for the whole summer and settle themselves in cottages, and those who go for a few days or a week and stay at the hotels. This latter class, desiring to see and do everything during their limited stay, are on the go from early morning till late at night; they really work harder and consume more muscular tissue than they would do in the same time at home. Consequently their appetites are unnaturally great, and are still further increased by the liberal indulgence in alcohol which seems almost universal among men at the sea-shore—for those who are very abstemious at home seem to find in the salt air a something that increases or originates a desire for alcohol; and these great appetites are allowed unbridled indulgence in crabs and oysters and the like, until a severe colic calls a halt. Late hours are the rule among these transient visitors, and matutinal headaches are not unknown. When to excessive eating, drinking, and labor (for amusement), we add the improper methods of bathing, about which we write elsewhere, we can readily understand why these visitors of a week go home exhausted. The hops also furnish a source of danger. The rooms are

hot, from the presence of hundreds of gaslights and of persons, and when a young man and his partner, heated above 100° F. by dancing, slip out to promenade on the piazza, subject to a strong wind, we can readily understand how a tendency to disease of some internal organs may be lighted into activity—for it is an ancient and erroneous superstition that one cannot "take cold" in salt air.

The "cottagers" lead a quieter life, and hence derive more benefit from the invigorating and life-giving atmosphere; but even this class participate more or less in the dissipations of sea-shore life. Of course, young folks go to the sea-shore "for fun," and they are going to have it, no matter how much we "old fogies" may preach against their methods. Still, this fact does not relieve us from the responsibility of pointing out what we consider hygienic errors in sea-shore life.

NOTES AND COMMENTS.

The Retention of Hair in the Axilla.

Evolutionists will be interested in reading the following remarks which Dr. A. Wyndham Martin publishes in the *Edinburgh Med. Jour.* for June, 1884:

The different views held on this subject render the question one of great interest to the student of science. The only reference to the subject made by Darwin, in the "Descent of Man," is the following:

"That the hair is chiefly retained in the male sex on the chest and face, and in both sexes at the junction of all four limbs with the trunk favors this inference—on the assumption that the hair was lost before man became erect, for the parts which now retain most hair would then have been most protected from the heat of the sun."*

Amongst many other theories held are the following:

1. That the hair in the arm-pit is intended to reduce the friction caused by the movements of the arm.
2. That at the age when the hair makes its appearance there is a greater supply of blood to the part.
3. That the increased heat serves to develop the hair follicles and sebaceous glands in greater abundance.

* Descent of Man, 2d edition, p. 57.

With regard to No. 1, any person on a slight examination of his own arm-pit will find that there is no friction at the part where the hair is most developed. As to 2, if due to an increased supply of blood to the axilla, it should also appear on the mammary region in the female—as there we see a much greater change in the blood-supply at the age of puberty. With regard to 3, the development of hair on the face in the male at about the same age is not generally attributed to an increase of heat and consequent development of hair follicles and sebaceous glands. If it be so in the axilla, why should the female lack hair on the face, considering that both sexes share in the possession of it more or less in the axilla? If we examine the subject morphologically instead of physiologically, we see that the axilla, the inner part of the fore limb, corresponds to the groin, the inner part of the hind limb. Now the presence of hair in the pubic region is sufficient, by the law of “correlation of growth,” to account for the presence of hair in the corresponding part of the fore limb, the axilla. On examination it will be found to bear a fixed ratio to that of the pubes, and also to correspond closely in color. Sexual selection in primitive man, before he clothed himself, is sufficient to account for the hair on the pubes. The sexual passion in both sexes will be found to be in proportion to the development of the pubic hair, and the “law of inheritance” will explain its persistence.

A Peculiar Form of Pneumonia.

Before the Manchester Medical Society (April 16, 1884,) Dr. Dreschfeld read a paper on a peculiar form of pneumonia, which seems to have been very prevalent lately in Manchester, and which was especially interesting, as it resembled in its symptomatology the “epidemic pneumonia” described by several observers in recent times. The disease commenced, as a rule, without a rigor, its onset being marked by general malaise and pyrexia, which lasted for two or three days before any characteristic physical chest-symptoms appeared. When these appeared, they had a very distinct creeping character: they consisted of fine crepitations, with dullness on percussion, and commenced at the apex of one lung, gradually passing downwards to the base, and then often attacked the other lung in a similar way. The characteristic rusty sputum was absent in about half of the cases, where there was either no expectoration at all, or expectoration of a muco-purulent character. The temperature was never very high, and the curve irregular. In

one case, where the invasion of each lobe was more sudden, every fresh attack was marked by a sudden rise of temperature. In but few cases was there a distinct crisis; where recovery took place the temperature showed a more gradual defervescence. The disease ran a somewhat protracted course, and was very fatal. Amongst its complications were noticed enlargement of the spleen, pericarditis, and albuminuria. Post mortem, the lungs showed typical croupous pneumonia, the several stages of which could often be seen in the same lung. Portions of the lung, placed at once in absolute alcohol, and examined after Gram's method, showed the presence of enormous masses of diplococci; these were seen both in the alveoli amongst the exudation, as well as in the lymphatics and capillaries. This form of pneumonia bore a very close resemblance to the pneumonia which occasionally occurred epidemically, as described by Costello, Jürgensen, Kühn, and others; it also resembled the pneumonia observed complicating typhoid fever and other zymotic diseases, and the pneumonia observed in old people and in alcoholics. It seemed to form a connecting link between the ordinary pneumonia and the so-called septic and the epidemic pneumonia. The inferences which Dr. Dreschfeld drew from his observations were these:

1. However much croupous pneumonia might vary in type and symptoms, there was only one kind of pneumonia.
2. The causes, such as catching cold, etc., were simply predisposing and not exciting causes.
3. Pneumonia was due most probably to a specific infective agent, the pneumonia-coccus.

Carbolic Treatment.

Before the Irish Academy of Medicine, (March 26, 1884) Dr. Cahill, in a paper on carbolic treatment, said that antisepticism was superfluous, as fermentation never occurred in the vital fluids, blood, pus, serum and lymph, until they died, and when once dead they should be removed. He traced an analogy between blood and pus, in that both died in the largest containing vessels first, and that dead substance introduced into either surrounded itself with a zone of dead material; for instance, dead bone in pus. He attempted to prove that air was a foreign body, by quoting the phenomena of canalization, and in other ways. He deprecated the system of classing a large number of drugs under the heading “antiseptics,” and thought each substance should be regarded on its own

merits, alleging that, although antisepticism was useless, the carbolic treatment was highly valuable in wounds and sores of a strongly inflammatory tendency, as devitalizing or suspending vital processes in the tissue-elements. In support of this view, he instanced the effects of the spray on the hands of operators. Carbolism in preventing suppuration round sloughs (as adduced by Mr. Cheyne) was partly due to the same principle, and partly to that property of carbolic acid by which it promotes the absorbent powers of granulation-tissue. Mr. Thompson pointed out that Lister was by no means confined to the use of carbolic acid in his treatment, but used perchloride of mercury, eucalyptus, thymol, etc. He dissented from Dr. Cahill's conclusions, and said that Lister's system had the effect of reducing the death-rate and practically wiping out in surgical practice pyæmia and septicæmia.—Mr. W. Thornley Stoker thought Dr. Cahill's point was to give a new explanation of the way in which the effects ascribed to Lister were produced.—Dr. Cahill said he did not attack carbolic acid, but Listerism—carbolic acid being, in proper cases, a very valuable drug. He quarrelled with Lister for using it indiscriminately in all cases, and thought Lister had done a great deal of harm by introducing antiseptic surgery. No doubt Lister used thymol, eucalyptus, etc., but he had gone back to carbolic acid, as mentioned in Cheyne's *Surgery*, which, according to Lister, himself, was the best source of information as to his system.

Case of Diphtheria Treated by Tracheotomy, Peptonized Enemata and Iodoform.

Dr. R. Shingleton Smith reports this case in the *British Medico-Chirurgical Journal*, March 1, 1884:

Florence H., æt. 6, admitted December 26, 1883, in state of asphyxia, with abundant exudation visible in throat. Tracheotomy was performed immediately, and gave marked and immediate relief.

December 27. Temperature was 102°, urine had one-eighth albumen, and there was much swelling of cervical glands.

December 30. The edges of the wound were gaping, stitches had sloughed out, and glands very much swollen.

December 31. Milk taken in by mouth at once came out through the tracheal tube and gave rise to much choking cough. Nutrient enemata of peptonized milk, and Slinger's capsules, were given; all food by the mouth discontinued.

January 4. The child was wasting rapidly, al-

though the temperature was normal, and threatened pneumonia had cleared up. The enemata not being well retained, peptonized milk was injected into the stomach through an œsophageal tube, but was only partially retained. The tube in trachea was then removed; the sloughing of wound had ceased, the swelling of glands subsided. In a few days the child could swallow solid food, although liquids would still pass down the larynx. The wound in the neck gradually healed, the opening in trachea closed, power of deglutition both of solids and liquids returned. The child rapidly improved in strength; speech returned in about a month, and the urine was free from albumen six weeks after admission.

The only essential element of treatment, other than by tracheotomy, peptonized enemata and œsophageal injections, was iodoform. This was given in grain-doses with mucilage every four hours during the first five days, till the power to swallow was lost. Iodoform was also painted on the fauces, and diffused in vapor throughout the air of the steam-bed. It was also applied to the wound and over the tube in the form of iodoform wool.

Bronchial Gangrene from a Foreign Body.

The *Wien. Med. Blätter*, of January 24 and 31, describes a case of bronchial gangrene occasioned by the inspiration of a small piece of bone. The patient was a strong man, aged thirty-seven, who came to Dr. Mader's clinic in Vienna on December 20, 1883, with the history that on November 15, as he was eating some soup, he swallowed a piece of bone, which stuck in his throat. This caused so much dyspnoea, that he was obliged to spend the night sitting up in a chair. Next morning he saw a medical man, who used a bougie, and relieved him from the sensation of the presence of a foreign body. He rested from work for four or five days, but soon afterwards he was seized with rigors, pain in the right side, and severe cough, apparently from having caught cold in a cellar. On admission, he had a certain amount of fever, and the respiration was hurried, but there was no sinking-in of the jugular regions. There was dullness on percussion over the right side, with some tenderness posteriorly, over the region of which no breath-sounds could be heard, the respiration elsewhere being vesicular. The sputa were not fetid, but the patient remembered that the mucus he spat up three days after the accident had a bad smell. Fætor appeared in the course of the three days following his admission, as the cough grew more severe, and the case went

on, with increasing fever and foetid expectoration, until January 5, when it ended fatally, with symptoms of suffocation. At the necropsy, the lower division of the right bronchus was found completely stopped up by a piece of bone; putrid bronchitis was found on both sides, and lobular pneumonia in the left lower lobe. A small solution of continuity was found on the posterior wall of the larynx, on a level with the arytenoid cartilage, showing that the piece of bone must have stuck there in the first place; and a similar lesion at the bifurcation of the trachea pointed to a second stoppage of the foreign body, before it slipped finally into the right bronchus, where it was found. The case contains a caution from a clinical point of view, as the use of the laryngoscope, indicated by the dyspnoea, might have shown the true nature of the case at the beginning.

A Case of Floating Liver.

Dr. J. B. Arini describes an interesting case of floating liver in a recent number of the *Anales del Cereulo Medico Argentino*. The patient was a young married lady, in whom the abdominal muscles were weak and flaccid after child-bearing. Wishing to put on a new dress which was found to be too tight, she, with the aid of another person, forcibly squeezed herself into it by lacing her stays extremely tight. Thus compressed, she started for church, but, before arriving there, was suddenly seized with an internal pain and sensation of tearing, which caused her to faint. Symptoms of peritonitis followed, obliging her to remain in bed for some time. On the subsidence of the peritonitis, a large swelling was noticed in the middle and right side of the abdomen. This tumor, which was movable, caused her great pain on walking, and she could only sleep on the right side. Dr. Arini first saw her eighteen months after the accident; he then verified the presence of a tumor, presenting the character of the liver. The anterior surface was smooth and convex, and not painful to gentle pressure; its lower border was sharp with a notch, its upper border thick and smooth; the tumor was movable, and could be raised upwards and to the right under the false ribs; the normal dull zone in the right hypochondriac had given place to a clear tympanitic sound. The periodical changes observed in the tumor coinciding with digestion, its movability, the subjective phenomena of weight and traction, and the physical signs, added to the history of sudden onset, recent confinement, and pendulous abdomen, all made the diagnosis clear. The treatment consisted in the employment of a species

of support or corset, with a concave metal plate well padded, on which the thin border of the liver rested; the organ by this means was held up more or less in its normal position. The patient found great relief from this support, and was able to walk and to lie on the left side without difficulty.

An Important Point in Testing for Albumen.

It is customary for the physician to request his patient to send him a sample of urine passed the first thing in the morning, when he desires to examine it for albumen. That this may mislead him is suggested by the following case, which a correspondent reports in the *British Medical Journal*, July 5, 1884:

A girl, aged 13, fairly healthy, but not over strong, was brought to him about ten months ago, said to be suffering from "incontinence of urine" and debility. On examining the urine, he found that it was loaded with albumen; there was no anasarca, and no cardiac mischief. He prescribed tincture of perchloride of iron and dilute nitrohydrochloric acid, with the result that nearly all trace of albumen had disappeared in about six weeks, when she went to the seaside, and he lost sight of her for about two months. Soon after her return he again examined the urine, and found it loaded with albumen. He again prescribed the iron and acid, and gave directions that the urine first passed in the morning should be sent to him for examination regularly every few days. This was done, and he was glad to find almost immediately marked improvement, until one day, by mistake, urine voided in the middle of the day was sent, and this he found to be loaded with albumen. He then gave directions that two samples should be sent on the same day every week, one being that passed the first thing in the morning, and the other later in the day. The result of his investigation was, that the former was perfectly normal and free from albumen, and the latter was decidedly albuminous. The amount of albumen varied, sometimes being considerable, sometimes hardly perceptible. At the present time the morning urine is perfectly free, but that passed at midday contains a decided trace, and this state of things has existed for some weeks past.

Peritonitis in an Infant.

To the New York Pathological Society (April 9, 1884), Dr. J. Lewis Smith reported this case. He had seen the patient only the day before its death, which occurred on the fourteenth day after

birth, in which there had been nothing unusual. A week before his visit the nurse said the child had been very fretful. An increase in the temperature was afterward noted. He found evidence of peritonitis. There was great distension of the abdomen, with meteorism; the child cried when pressure was made over the abdomen. The rectal temperature was 102.4° F. During the first ten days of life the child had only gained one ounce in weight. Some matter could be squeezed from the umbilicus. The cord had separated at the seventh day. The autopsy was made by Dr. Welch. The most marked lesions were found along the course of the umbilical cord, where fibrinous pus was quite thick. The lymphatic vessels along the lower surface of the diaphragm were also filled with pus, and Dr. Welch had stated that there probably would have been an extension of the inflammatory process to the pleura had the child lived longer. The umbilical vein was filled with grayish-red, broken-down, and purulent thrombi, closely adherent to the walls of the vessel. Dr. Welch explained the peritonitis by the statement that micrococci, which were present, had found their way through the umbilical vein into the peritoneal cavity, and this fact also explained the reason for there having been a greater degree of inflammation along the course of the vein. Dr. Smith said that if this explanation of peritonitis in these little patients was accepted by pathologists, it was interesting and suggestive. Some weeks ago there had been some puerperal fever and erysipelas in the maternity wards of the institution where the child died, and for that reason the wards were closed for a time. Whether the present case was in any way connected therewith, he was unable to say.

Idiopathic Purulent Peritonitis.

Prof. Leyden has recently described (*Deutsche Med. Wochenschrift*, April 24,) three cases of idiopathic peritonitis. One of these, in a male, ended in recovery, so that its precise diagnosis remains uncertain. The other two were in females, aged twenty and twenty-seven years respectively, and the peritonitis, which was purulent, ran a rapidly fatal course. It had no connection with menstruation, and the post-mortem examinations showed the absence of any local primary inflammation of the pelvic or abdominal organs. In one of these cases the interesting discovery was made of an abundance of micrococci in the exudation, as well as in the deeper layers of the abdominal wall and the diaphragm. They resembled the micro-organisms which have been met with in puerperal

peritonitis and other purulent exudations—e. g., pleurisy. The origin of such cases is veiled in obscurity; but perhaps, as Leyden thinks, the detection of these micro-organisms may lead to an explanation, which at the best must be hypothetical—viz., that in intestinal or menstrual derangements such organisms may gain access to the peritoneal cavity and excite inflammation. He speaks somewhat despairingly of treatment, including mercurial inunction, and says that it has long been a question with him whether such cases ought not to be dealt with surgically, on the same principles that an empyema is treated. The difficulty of establishing a diagnosis of the nature of the peritoneal effusion in these very acute cases forms perhaps the main hindrance to the adoption of a measure which might often be the sole means of saving life.

Catheters and Self-Catheterism.

While much more common in England, yet, the custom of *self-catheterism* is becoming more usual in this country. And as gum catheters (the kind most in use) become very sticky, increase in bulk and deteriorate in quality, becoming very liable to break off in the urethra, it is with much satisfaction that we note that Dr. J. B. Mitchell states in the *Medical Press*, June 25, 1884, that a catheter that has been smeared inside and outside with oil, when exposed for an hour or two to the action of pyroxylic ether, is as clean and smooth as it was before use. He also suggests a most excellent method of using oil for lubricating purposes. When a certain quantity of castor oil is, by exhaustion at the superior orifice of the catheter, sucked into the tube of the instrument, it does not at once seek to escape, but keeps its place till the constricted part of the urethra is reached. The catheter, with its internal as well as external charge of lubricant, having arrived at the point where resistance has to be overcome, pressure of a stripping character exerted between the finger and thumb, in a downward or inward direction, upon the extruding upper end of the instrument, by expelling the oil wherewith its opposite end is charged, floods the urethra with the lubricant at the constricted part, and bears along, as it were, the catheter point through the prostatic rapids, landing it safely in the bladder. Experience has abundantly shown that the flooding, when copious, is always completely effectual in the shooting of the urethral narrows.

Cleansing the Uterus after Abortion.

Dr. David Inglis publishes a paper on this sub-

ject in the *Am. Jour. Obstetrics*, April, 1884, in the course of which he says:

"My experience with intra-uterine injections in the cases under consideration has been markedly and uniformly favorable. By the use of the double tube, the danger of any of the injected fluid being forced up the Fallopian tube is practically none. The effect of disinfectant injections in reducing temperature in cases where constitutional disturbance had already set in, has been unequivocal. In one case in which I was called to a patient in whom a portion of placenta retained had caused a temperature of 105.5°, the drop to 99° within three hours after thorough disinfection of the uterine cavity gave most distinct evidence of the efficacy of the treatment. While I have never as yet had any untoward effects from the use of intra-uterine injections, it is right to add that it would seem that their use long (six or seven days) continued after confinement tends to increase the danger of late post-partum hemorrhage.

In conclusion, I would specially call attention to flexion of the uterus as a cause of retention of the lochial discharge, and thus of certain cases of puerperal fever. The mention of it at once suggests the reasonableness of prompt reposition and thorough cleansing.

Low Temperature in Pneumonia.

Before a recent meeting of the New York Clinical Society, Dr. Janeway called attention to the significance of low temperatures in pneumonia. He had recently seen three cases, two of which proved fatal, and the third, which was still under observation, would probably result in the same way. The first case was that of a woman, fifty-five years of age, whom he had seen on the sixth day of the disease, hæmoptysis having given rise to the suspicion of phthisis. He found well-marked consolidation at the base of one lung, and some signs on the other side. The rectal temperature was only 100° F. The patient died on the ninth day. In the second case he saw the patient on the fourth day, and there had been no marked elevation of temperature. Here, also, the physical signs were plain. In the third case, the highest temperature noted thus far has been 102°. Such cases used to be called asthenic pneumonia. For several days before taking to bed, the patients were often sick without any marked rational symptoms, or the symptoms might be misleading, like the hæmoptysis in one of the cases he had referred to; and yet they might die a day or two later. He thought this low temperature a bad

symptom, although he had seen it followed by recovery. In the cases referred to, the pulse had been rapid—in the first one from 150 to 160, in the second from 120 to 130. He also called attention to the fact that apex pneumonias were often overlooked, because the physician examined only in front, and the signs were not usually to be found there, but high in the axilla and behind. The percussion-note in front was often vesiculo-tympanitic from imprisoned air. Many such cases were diagnosticated as remittent fever.

Imperforate Hymen Opened without Antiseptic Precautions.

Dr. M. G. Biggs reports this case in the *Brit. Med. Jour.*, May 10, 1884:

"E. S., aged 16, a servant, had never menstruated, although she was a well-formed girl. She had, however, suffered from pain at distinct intervals, and, when she sent for me, her mother said she had been in severe pain all the previous night, and was then so bad that she was rolling on the bed, and that the womb had come down externally. On examination there was a distinct bluish projecting membrane, with marked fluctuation; the only opening to be found was that of the urethra. A triangular piece was removed from the centre of the membrane, and there was an immediate rush of a considerable quantity of dark-colored discharge, with instant relief from the pain, which did not recur. When the discharge had ceased, the parts were covered with a piece of linen rag soaked in carbolic acid lotion (1 in 40), and this was ordered to be continued; but, as often happens in this class, the mother was somewhat careless, the rag was allowed to dry or to fall off, so that we may fairly say that there was a free access of non-carbolized air. She was kept in bed during the remainder of that day and the next, but there was no rise of temperature, and then she was allowed to get up and resume her work, which she did without any bad effects."

The Therapeutics of "Horizontal Position."

Dr. R. H. Gunning, of Edinburgh, tells us that it is enough to look at the veins on the back of the hand or inside of the leg, to see the effects of hydrostatic pressure. The limbs being perpendicular, the veins swell; placed horizontally, they become again normal. If so in the limbs where the veins have valves, more so in the veins where there are no valves, as in the lower intestine and in the reproductive parts. How easy to prevent varix, varicocele, piles, and leucorrhœa, by re-

clining sufficiently; or to develop them by over-
standing or over-walking. This is what he thinks
is not sufficiently estimated in books nor in prac-
tice. Too much is expected from local applica-
tions or operations of one kind or another, and too
little is trusted to the help of position, or phys-
ical law.

Then we must not forget that the force of the
heart and general circulation is also diminished
by the recumbent position. The pulse increases
in frequency by sitting up, and more by stand-
ing up.

Septicæmia Accompanying Lacerated Cervix.

Dr. William W. Seymour contributes a paper
on this subject to the *Am. Jour. of Obstetrics*,
April, 1884, which is thus summarized:

1. Until the cervix is fully dilated, the present-
ing part must be kept back and the cervix sup-
ported to prevent its laceration by the presenting
part or the after-coming shoulders.*

2. Hot water injections will, immediately after
delivery, make lacerations of cervix and vagina
patent which otherwise would not be discovered
by the touch for several days.

3. In every case of suspected cervical laceration,
a careful search should be made with the
uterine sound for supra-vaginal cervical lacerations.

4. Large doses of quinine, twenty or so minutes
prior to the uterine injection, will prevent chill
and probably also uterine colic.

5. A supra-vaginal laceration of the cervix
should be treated by the armed probe and irrigation.

6. Examination within the first few days after
labor would probably show a fair percentage of
peri-uterine hematomata from laceration.

Uræmic Amaurosis.

Dr. A. Friedenwald thus summarizes a paper on
this subject in the *Med. News*, August 9, 1884:

1. That when amaurosis suddenly overwhelms
a patient in both eyes with no ophthalmoscopic
change, uræmia should be suspected even in the
absence of any other prominent uræmic symptom.

2. That uræmic amaurosis will continue only
as long as the uræmia exists, and will disappear
when the function of the kidney is re-established.
When permanent injury to sight is observed, it
may be due to pre-existing retinal changes, not at
all uncommon in Bright's disease.

*Probably, apart from instrumental cases, the worst cases
of laceration of perineum or cervix are produced by the
shoulders.

3. That the chances for a full return of sight
are somewhat impaired when the patient has been
the subject of recurring attacks.

4. That by exhibiting jaborandi and other
means for inducing free diaphoresis and by free
purgation a catastrophe may be averted in the
general forms of uræmia, but when it occurs in
pregnancy, premature labor is the only remedy
which promises safety to the patient.

Ammonia as a Prophylactic Against Cholera.

Dr. S. W. Ingraham, of Chicago, writes to the
Med. Record: "During the years 1865 and 1866
I spent much of my time in New York city, and
as the cholera was quite epidemic there during
those two years, I took occasion to ascertain what
class of people were least subject to it. I found
that the men who worked in horse stables were
rarely, if ever, attacked with the disease, and
that their families were less liable to the contagion
than persons of other occupations living in the
same localities, with the endemic influences nearly
or quite equal. Upon special examination I found
the clothes and even the skin saturated with am-
monia to such an extent that when they came in
close proximity to me I could plainly discern its
odoriferous properties. From this I was led to
believe that their whole bodies were more or less
under the influence of the ammonia, and that the
cholera contagion would not attach to them."

NEWS AND MISCELLANY.

Sad Suicide of a Medical Man.

An inquest was lately held at Northwich, in
Cheshire, England, on the body of Dr. Cadwalla-
der Brooke Wolseley, a cousin of General Lord
Wolseley, who committed suicide by taking a
large dose of hydrocyanic acid. The deceased
was in practice in Northwich, where he was
greatly respected by the inhabitants, and had
been engaged in seeing and prescribing for pa-
tients up to within an hour previous to the
commission of the fatal act. No evidence was
forthcoming at the inquiry to indicate any sort of
cause for the occurrence, but one witness desired
to explain that deceased had been subject to
pains in the head, and had suffered from a slight
sunstroke some years ago. Strangely enough,
however, the coroner, Mr. H. Churton, decided
that this evidence could not be entertained; why,
he does not appear to have said. To ordinary
understandings it would have been of essential
service in helping to elucidate the circumstances
of the case, and it might have been more gener-
ally satisfactory had the testimony been admitted.
The verdict ultimately recorded was to the effect
that death was caused by taking prussic acid, and
that deceased was laboring under temporary in-
sanity at the time.

British Medical Association.

The fifty-second annual meeting of this Association was held in Belfast, Ireland, July 29, 30 and 31, and August 1, 1884.

The president's address was delivered by Dr. James Cuming. The address in Medicine, by Dr. William M. Ord. The address in Physiology, by Dr. Peter Redfern. The address in Obstetric Medicine, by Dr. George H. Kidd. "Old and New Views in Medical Science," by Dr. James W. T. Smith. "Gastrostomy; Radical Cure of Hernia; and Thyroidectomy," by Sir William MacCormac. "The Surgical Aspects of Obstetrics and Gynecology," by Dr. Clement Godson. "The Cholera Microbe, and How to Meet It," by Dr. Charles Cameron. "The Treatment of Immature Cataract," by Dr. W. A. McKeown. "The Pathology of Insanity," by Dr. George Henry Savage. "The Relations of Physiology and Pathology," by Dr. W. S. Greenfield. "On Methods of Therapeutic Research," by Dr. T. J. MacLagan. "On the Nosological Relations of Chronic Rheumatic (Rheumatoid) Arthritis," by Dr. Dyce Duckworth. These are the principal papers so far reported. We will from time to time present abstracts of them.

Hydro-Therapeutics at Saratoga.

The *N. Y. Med. Jour.* says that in spite of the popularity of some of our American watering-places, and the vague trustfulness with which patients with chronic ailments resort to them, it must be said that, in comparison with those of other countries, our resources in the shape of mineral springs have not hitherto been turned to account therapeutically in any way deserving to be called systematic or intelligent. It is undoubtedly true that in certain parts of Europe the powers of mineral waters are magnified far beyond their real worth, and the indications for their therapeutical employment over-refined; but it is very certain that we have erred in the opposite direction. It is on all accounts to be desired that a systematic study should be made of those of our waters that have been conceded to have any just pretension to definite medicinal properties, and we are glad to learn, therefore, that one of the resident physicians of Saratoga, Dr. R. C. McEwen, is about to enter upon the study of the Hathorn spring, somewhat after the manner of the bath physicians of Europe.

The Plague on the Turco-Persian Frontier.

The Berlin correspondent of the *British Med. Jour.* (July 26, 1884), writes: "About the middle of June a telegram reached Berlin announcing the outbreak of bubonic plague in the neighborhood of Bagdad. Some days ago, news reached Berlin, from St. Petersburg, that, in consequence of the outbreak of a malignant epidemic on the Turco-Persian frontier in Kerbala and the neighborhood, the Persian government had drawn a strict cordon to prevent the plague from spreading. The governor of Baku has refused to grant passports to pilgrims wishing to go to Kerbala, in order to prevent the epidemic being brought to the Caucasus. The nature of the epidemic is not announced." This is probably the same plague that was spoken of in June. News has also reached

Berlin, from St. Petersburg, that the Siberian plague is now raging in the government of Pleskoff, and that several deaths have already occurred. It is, moreover, asserted that the authorities are not taking proper measures against the plague.

The Late Mr. Hawkins.

Speaking of the late Mr. Caesar Hawkins, Sergeant-Surgeon to the Queen of England, the *London Med. Times* says:

"Like the majority of those who have attained high rank in the profession of medicine, Mr. Hawkins was a man of character as well as ability. One who knew him for nearly fifty years writes of him: 'During all these years he was ever the same—most industrious and painstaking in all matters relating to his work—high-minded and honorable in all that was connected with the interests of his profession—kind and liberal to a degree, that truly it may be said, his right hand knew not what his left gave away. All who had the privilege of his friendship will endorse this estimate of his character. He was one of the most accurate and clear-headed of men that I had ever anything to do with—no lover of ostentation—no seeker after personal advancement by show or talk—but true in every sense of the word, and a thorough high-minded gentleman.'"

A Point in Abating Nuisances.

The right of courts to abate nuisances is an undoubted one, but great care is exercised lest injustice may be done by the hasty exercise of this power. A good illustration of the extent to which courts will go in this direction is shown in a recent English case, where a railroad company had established cattle-yards in a place where they soon became a great nuisance and offensive to health. The company was allowed by law to establish such cattle-yards, but the act of Parliament said nothing as to what should be done in case they became a nuisance. Upon a motion to enjoin the railroad company from continuing the yards, the company did not in answer show that the location chosen was the only place where cattle-yards could be placed; and as this was not done, an injunction was directed to issue.

The Berlin Physicians and Cholera.

The Berlin Clinical Society (*Verein für innere Medicin*) at the meeting on the 14th of July, discussed the subject of cholera. Dr. S. Guttman opened the debate, and recommended the formation of a committee to collect and report upon the relative value of various therapeutic measures, and consider what influence the discovery of the cholera bacillus should have in the adoption of prophylactic and curative methods. An animated discussion followed, and a committee was nominated consisting of Drs. Leyden, Fränzel, Klaatsch, Reiss, Goldammer, Lehnert, Baer, Wernich, P. and S. Guttman, and Guttstadt. Dr. P. Guttman stated that accommodation for 500 cholera patients could be provided in the city hospital at Moabit. At the commencement of the sitting, Dr. Kronecker exhibited a newly-devised apparatus for saline transfusion.

Medicine in Syria.

Dr. George E. Post, a medical missionary connected with the Presbyterian Church of this country, who is living at Beirut, Syria, has acquired a great reputation among the Turkish officials for his skill in surgery, and could easily acquire a large income if he were to receive pay for his services. He devotes, however, his entire time to the poor, and the calls upon him are immense in number and in variety. He has prepared a series of text-books in Arabic on surgery, materia medica, botany, zoology, and physiology, and edits a monthly medical journal. He is at present employed on a work descriptive of the flora of Syria and Palestine, the first work of the kind on the subject in any language.

Milk vs. Stimulants.

"The greater my experience becomes," writes Dr. Clauston on Annual Report of the Royal Edinburgh Asylum for the Insane, "I tend more to substitute milk for stimulants. In very acute cases, both of depression and of maniacal exaltation, when the disordered working of the brain tends rapidly to exhaust the strength, I rely more and more on milk and eggs made into liquid custards. One such case this year got eight pints of milk and sixteen eggs daily for three months, and recovered under this treatment. I question if he would have done so under any other. He was almost dead on admission, acutely delirious, absolutely sleepless, and very nearly pulseless."

Items.

—Mr. Caesar Hawkins, Sergeant-Surgeon to the Queen of England, died July 20, aged 86 years.

—Dr. P. M. Wise has been appointed Superintendent of the Willard Insane Asylum, in place of Dr. Chapin.

—Another fatal accident has occurred in the Alps, the victim being a medical student, son of Professor Banberger, of Vienna.

—The American Academy of Medicine will hold its annual meeting at Baltimore, Maryland, on Tuesday and Wednesday, October 28th and 29th, 1884.

—M. Paul Bert has proposed in the French Chamber a law which compels every doctor to report without delay the appearance of a case of cholera.

—M. Closmadeuc has recently performed the Cæsarian operation successfully both for mother and child. This makes his third operation and third success.

—The University of Heidelberg is about to celebrate its five hundredth anniversary. The Baden Parliament has voted \$40,000 to meet the expenses of the occasion.

—In the *Edinburgh Med. Jour.*, Aug., 1884, Dr. A. D. Leith Napier reports a fibrous polypoid uterine tumor, with secondary hemorrhages, and removal of tumor.

—The Academy of Medicine of Paris has, on the report of Dr. Brouardel, unanimously voted that quarantine on land is impracticable in France, and that the process of disinfection at present imposed upon travelers and their luggage is inefficacious.

—The Trustees of Jefferson Medical College have had placed in their hands the resignation, by Prof. Robert E. Rogers, of the Chair of Chemistry in that school.

—"Congestion of the right kidney" is the diagnosis made by his attending physician of an indisposition from which Rev. Henry Ward Beecher has been suffering.

—Prof. Aebly, of Berne, has been appointed to the Anatomical Chair of the German Medical Faculty of the University of Prague, and Prof. Strasser is named as his successor at Berne.

—The French government has conferred the Order of the Legion of Honor upon Prof. Koch, in recognition of his services in connection with the investigation into the causes of the outbreak of cholera.

—The National Board of Health held an annual meeting in Washington, Wednesday, July 30, and elected the following officers:

President—Dr. James L. Cabell, Virginia.

Vice-President—Dr. Stephen Smith, New York.

Secretary—George E. Waring, Esq., Rhode Island.

—The executive committee of the commission appointed at the recent session of the Legislature to investigate the sanitary condition of the tenement houses of New York, commenced the work of inspection during the last week of July. It consists of Drs. Moreau Morris and Abbot Hodgeman, Charles F. Wingate, Sanitary Engineer, and William P. Esterbrook, Superintendent of Buildings.

—One of the comic papers has this paragraph: "A patent medicine manufacturer died in New York last week. Before he died, his friends asked him how he would like to be buried. He had just strength left to say: 'Insert me top column, next to reading matter, 52 times, electro by mail,' and then he closed his eyes and passed away to that bourne where there are no omissions nor wrong insertions."

—The English Parliament has refused to pass the bill forbidding pigeon-shooting matches, although the *London World* says: "It was abundantly proved in the course of the debate that pigeon-shooting entails the systematic practice of the most execrable cruelties. The physical injuries done to the birds in order that they may baffle the marksmen, or that they may be more difficult to hit, are of the most hideous description."

—At the suggestion of Dr. Cyrus Edson, of the New York Health Department, an ordinance has been passed forbidding the use of vessels made of brass, lead, copper, or other metallic substance in the sale of beer, soda-water, syrups, and other beverages or flavoring materials, on account of the danger of the formation of compounds detrimental to health. An investigation into the character of the lining of the soda-water fountains of Brooklyn is at present being made by Health Commissioner Raymond.

DEATHS.

FLEMING.—August 9, 1884, at the residence of his parents, Dr. W. and E. J. Fleming, Port Byron, Ill., Charles S. Fleming, aged 17 years, 1 month, and 20 days, of cerebral disease.